

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3891

CERTIFICATE OF DEATH

03875

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Deaf Island</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>1 day.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Deaf Island</i>		d. STREET ADDRESS <i>Mari Road.</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Pennine General Hospital</i>				d. STREET ADDRESS <i>Mari Road.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>Hobley</i>	Middle <i></i>	Last <i>Abbott</i>	4. DATE OF DEATH <i>March 17</i>	Month <i>March</i>	Day <i>17</i>	Year <i>1958</i>				
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 12 1886</i>	9. AGE (In years lost birthday) <i>71 yrs.</i>	10. IF UNDER 24 HRS. Months <i></i>	Days <i></i>	Hours <i></i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF THAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Smith</i>		14. MOTHER'S MAIDEN NAME <i>SARAH</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16. SOCIAL SECURITY NO. <i>—</i>					
17. INFORMANT <i>Hubert Abbott - Moire Md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), slotting the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>493x Pneumonia, Right lobe</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>		20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3/17</i> , 1958, to <i>3/17</i> , 1958, that I last saw the deceased alive on <i>19</i> , and that death occurred at <i>2:01 P.M.</i> from the causes and on the date stated above.		ACTUAL SIGNATURE <i>David Schinner</i>		PHYSICIAN'S NAME (Type) <i>M.D.</i>		ADDRESS (Street, city or town, state) <i>Salisbury Md</i>		DATE SIGNED <i>Mar. 17 1958</i>			
22. BURIAL, CREMATION, REMOVAL (Sp. City) <i>Burial Mar 19 1958</i>		23. DATE THEREOF <i>Mar 19 1958</i>		24. NAME OF CEMETERY CREMATORIUM <i>St John's Methodist</i>		25. LOCATION (City, town, or county) <i>Deaf Island Md</i>		(State) <i>MD</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>D. B. Webster</i>		ADDRESS <i>Deaf Island Md</i>		24a. REC'D BY REGISTRAR <i>RESEARCH</i>		24b. REGISTRAR'S SIGNATURE <i>RESEARCH</i>					
VS A15 (4) 15M 9/55		DATE MAR 21 '58									

OPTIONAL FORM NO. 10 - MARCH 1958 EDITION
GSA GEN. REG. NO. 27

CONTINUATION OF DELETION

BUREAU V. S.

MAR 21 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3892 CERTIFICATE OF DEATH

03876

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 4 1/2 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle Lymos last Alston		4. DATE OF DEATH March 17th 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Alston		14. MOTHER'S MAIDEN NAME Sallie ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. 137-18-0733	
17. INFORMANT Deer's Head Hospital Records, Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 260 X		INTERVAL BETWEEN ONSET AND DEATH 1 MO.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Glomerulosclerosis		?	
(c) DUE TO Diabetes mellitus		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic cardiovascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 23, 1957 , to March 17th 1958 , that I last saw the deceased alive on March 17th 1958 , and that death occurred at 1:55 PM , from the causes and on the date stated above. ACTUAL SIGNATURE V. Juerman M.D. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 3/17/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/23/58	
22c. NAME OF CEMETERY OR CREMATORIUM St. James A.M.E. Cem.		22d. LOCATION (City, town, or county) Havre de Grace, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Elmer E. Bullock, Havre de Grace, Md.		ADDRESS 24a. REG'D BY REGISTRAR Mar 24 1958 DATE 24b. REGISTRAR'S SIGNATURE Elmer E. Bullock	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REGISTRATION

REGISTRATION OF DEATH

BUREAU X-8

MAR 24 1958

REGISTRATION

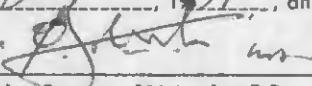
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03877

3893

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital			e. STREET ADDRESS 726 Parkway Circle			
3. NAME OF DECEASED (Type or print) ELIA		First WESTBROOK	Middle ATKINS	Last 726	4. DATE OF DEATH MARCH 11th 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Jan. 15, 1878	9. AGE (In years last birthday yrs.) 80	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Rosendale New York		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Silas Anderson			14. MOTHER'S MAIDEN NAME Mary DePuy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) No			16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Cornelia A. Simmons (Sister) 726 Parkway Circle - Salisbury, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. Cerebral Hemorrhage.						INTERVAL BETWEEN ONSET AND DEATH 7 days.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (b) DUE TO Atherosclerotic hypertensive cardiac disease.						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/5 , 19 58 , to 3/12 , 19 58 that I last saw the deceased alive on 3/12 , 19 58 , and that death occurred at 2:25 P.M. from the causes and on the date stated above.			ADDRESS (Street, city or town, state) M.D.			DATE SIGNED 13/158
ACTUAL SIGNATURE 		PHYSICIAN'S NAME (Type) Dr. Andrew Mitchell		Maryland, Ave. Salisbury, Md.		
PHYSICIAN'S NAME (Type) Dr. O.J. Burton		22b. DATE THEREOF Cremation Mar. 15/58		22c. NAME OF CEMETERY OR CREMATORIAL J.Wm Lee & Son Co.	22d. LOCATION (City, town, or county) Washington, D.C.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND		ADDRESS HOLLOWAY & COMPANY - SALISBURY MARYLAND		24a. REC'D BY REGISTRAR MAR 14 '58	24b. REGISTRAR'S SIGNATURE 	

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU U. S.

MAR 14 1988

RECEIVE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03878		
3973 CERTIFICATE OF DEATH.										Reg. Dist. No.		
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Allen c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Allen d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Walter	Middle S.	Last Banks	4. DATE OF DEATH 3 12 1958		Month	Day	Year			
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 8, 1888		9. AGE (in years last birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY —			11. BIRTHPLACE (State or foreign country) Fruitland			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Nicholas S. Banks			14. MOTHER'S MAIDEN NAME Mary Rock									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, Unknown) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Violz Banks		Address Eden, Md. Rt. 2						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 480X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO										INTERVAL BETWEEN ONSET/DEATH Week		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Myocarditis										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —										
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
21. I certify that I attended the deceased from March 14, 1958 to March 14, 1958 , that I last saw the deceased alive on Feb. 22, 1958 , and that death occurred at Allen M. from the causes and on the date stated above. ACTUAL SIGNATURE G. Herbert Sembley, M.D. PHYSICIAN'S NAME (Type) G. Herbert Sembley										ADDRESS (Street, city or town, state) Allen, Wicomico Co., Md. DATE SIGNED 3/14/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/15/58		22c. NAME OF CEMETERY Allen		22d. LOCATION (City, town, or county)		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Ward - Marion Sta., Md.		ADDRESS				24a. REC'D BY REGISTRAR DATE Mar 18 1958		24b. REGISTRAR'S SIGNATURE Quinton				

BUREAU V.

MAR 18 1958

RECEIVED

Miller McCormick

CHIEF M. PATT - Mission 2nd 1958
Miller McCormick

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Form G-238 11-10-58, ET

13879

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 yr. 9½ mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Callaway'	
3. NAME OF DECEASED (Type or print) Joseph		d. STREET ADDRESS —	
4. DATE OF DEATH March 4th, 1958	Month March	Day 4th	Year 1958
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 29, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY State Roads	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Barnes		14. MOTHER'S MAIDEN NAME Lucy Neal	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Deer's Head State Hospital Records, Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive cardiovascular disease		?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 13, 1955 , to March 4, 1958 , that I last saw the deceased alive on March 4, 1958 , and that death occurred at 6:20 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Salisbury, Maryland	
ACTUAL SIGNATURE V. Juerman		DATE SIGNED 3/5/58	
PHYSICIAN'S NAME (Type) V. Juerman, M. D.		Deer's Head State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/8/58	
22c. NAME OF CEMETERY OR CREMATORIUM Holy Face		22d. LOCATION (City, town, or county) (State) Great Mills, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE MAR 10 '58	
		24b. REGISTRAR'S SIGNATURE Q. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WISCONSIN STATE DEPARTMENT OF HEALTH - MADISON, WI

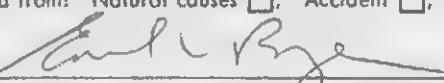
X

V. S.
BUREAU V. S.
RECEIVED
MAR 10 1968

03880

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY 3895 Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Delaware b. COUNTY Sussex	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) S Salisbury		c. LENGTH OF STAY IN 1B 1 hour	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel 441	
f. STREET ADDRESS 410 West 6th Street		d. DATE OF DEATH Month March Day 7 Year 1958	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First John	Middle Richard	Last Blake
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 27, 1941
9. AGE (In years last birthday) 16 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Franktown, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Kellum		14. MOTHER'S MAIDEN NAME Lillie Mae Blake	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-38-2242	
17. INFORMANT Mrs. Nellie Blake, Laurel, Delaware		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bullet wound of heart		Sudden	
DUE TO 981X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot during a quarrel with another man.	
20c. TIME OF INJURY Month, Day, Year Hour g. m. 3-11-58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street 20f. (City or town) Salisbury (County) Wicomico (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE 		DATE SIGNED 3-10-58	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 11, 1958	
22c. NAME OF CEMETERY OR CREMATORIAL Home Beneficial Cemetery		22d. LOCATION (City, town, or county) Stockton, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE Mar 12 1958	
ADDRESS		24b. REGISTRAR'S SIGNATURE 	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JAN 10 1973

SEARCHED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3896

CERTIFICATE OF DEATH

03881

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Delaware</i>		b. COUNTY <i>Sussex</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Delaware</i>		d. STREET ADDRESS <i>4</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Maude</i>	Middle <i>L.</i>	Last <i>Booth</i>	4. DATE OF DEATH	Month <i>March</i>	Day <i>15</i>	Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Aug 19, 1899</i>	9. AGE (In years last birthday) <i>28</i>	10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months <i>28</i>	Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Delaware</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>C. MILLER</i>		14. MOTHER'S MAIDEN NAME <i>Caroline Devin</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>W.M. P. McCANN SALISBURY MD</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Rheumatic heart insufficiency</i>		DUE TO <i>Rheumatic heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO <i>Rheumatic heart disease</i>		3 to 4 yrs			
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Obstruction; Nephrosclerosis</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 11:15 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>David J. Schum</i>		ADDRESS (Street, city or town, state) <i>Medical Center Salisbury</i>					
PHYSICIAN'S NAME (Type)		DATE SIGNED <i>3/16/58</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/18/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>ODD Fellows Cemetery</i>		22d. LOCATION (City, town, or county) <i>Laurel Del</i> (State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. L. Dickey</i>		ADDRESS <i>Laurel Del</i>					
		24a. REC'D BY REGISTRAR DATE <i>3/21/58</i>					
		24b. REGISTRAR'S SIGNATURE <i>Richards</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURZAU V.

MAR 21 1958

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3897

CERTIFICATE OF DEATH

Reg. Dist. No.

03882

1. PLACE OF DEATH a. COUNTY <i>WICOMICO</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>WICOMICO</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. LENGTH OF STAY IN lb <i>2 DAYS</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X PARSONSBURG</i>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>PENINSULA GENERAL HOSPITAL</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>GORMAN</i>	Middle <i>THOMAS</i>	Last <i>Brown</i>	4. DATE OF DEATH Month <i>MARCH</i>	Month <i>23</i>	Day <i>1958</i>	Year
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Sept. 5, 1948</i>	9. AGE (In years lost birthday) <i>9 yrs.</i>	10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months <i>6</i>	Days <i>18</i>	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School Boy</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Pen. Gen. Hosp Salisbury, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>Gorman Thomas Brown</i>		14. MOTHER'S MAIDEN NAME <i>Ethel Willard Tingle</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mr. Gorman T. Brown (Father)</i>		Address <i>Parsonsburg Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Renal Failure (Uremia)</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO <i>Hydronephrosis - (of long standing)</i>					
(c)		DUE TO <i>Congenital Anomaly of Urinary Tract - Posterior urethral valve</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>March 21, 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Medical Center, Salisbury, Md.</i>		20f. (City or town) (County) (State) <i>Parsonsburg, Maryland</i>	
21. I certify that I attended the deceased from <i>March 21, 1958</i> , to <i>March 23, 1958</i> , that I last saw the deceased alive on <i>March 23, 1958</i> , and that death occurred at <i>100 A.M.</i> , from the causes and on the date stated above							
MEDICAL CERTIFICATION INTERNAL SIGNATURE <i>Alfred C. Kolls</i>		ADDRESS (Street, city or town, state) <i>Medical Center, Salisbury, Md.</i>		DATE SIGNED <i>3/23/58</i>			
PHYSICIAN'S NAME (Type) <i>Dr. Alfred C. Kolls</i>		Medical Center Salisbury, Md. Mar 23, 1958					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Mar. 25, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Parsonsburg Cemetery</i>		22d. LOCATION (City, town, or county) <i>Baronsburg, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>HOLLOWAY & COMPANY - SALISBURY MARYLAND</i>		ADDRESS		24a. REC'D. BY REGISTRAR <i>MAR 27 1958</i>		24b. REGISTRAR'S SIGNATURE <i>John E. Kolls</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. S.

MAR 27 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3974 CERTIFICATE OF DEATH										Reg. Dist. No. 03883			
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>					b. COUNTY <i>Wicomico</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parsonsburg</i>					c. LENGTH OF STAY IN lb RURAL					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parsonsburg</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Home</i>					d. STREET ADDRESS <i>R.F.D. 2</i>					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>MARY</i>	Middle <i>Bundick</i>	Last <i>Bundick</i>	4. DATE OF DEATH <i>March 14 1958</i>	Month <i>March</i>	Day <i>14</i>	Year <i>1958</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 22, 1887</i>		9. AGE (In years last birthday) <i>70 yrs</i>		10. USUALLY OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		11. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		12. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
13. FATHER'S NAME <i>Samuel Drummond</i>		14. MOTHER'S MAIDEN NAME <i>Martha Ayres</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO (If yes, give war or date of service)		17. INFORMANT <i>Helen Strand - Jasley, Va.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4x0.1</i>		DUE TO <i>Coronary thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>		Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Chronic arteritis</i>				5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Parsonsburg</i>		(County) <i>Wicomico</i>		(State) <i>VA</i>			
21. I certify that I attended the deceased from <i>4/23/58</i> , 1958, to <i>3/14/58</i> , 1958, that I last saw the deceased alive on <i>3/14/58</i> , 1958, and that death occurred at <i>34 M.</i> from the causes and on the date stated above.													
ACTUAL SIGNATURE <i>Edgar Wharton - New Church, Va.</i>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/23/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Bayside</i>		22d. LOCATION (City, town, or county) <i>Parsonsburg, Va.</i>		(State) <i>VA</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar Wharton - New Church, Va.</i>		ADDRESS		24a. REC'D. BY REGISTRAR <i>MAR 24 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Parsonsburg</i>							

BUREAU V. S.

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REGELIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03884

3898

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Wicomico</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethel ISBURY</i>		c. LENGTH OF STAY IN 1b <i>2 weeks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Mandeville</i>		d. STREET ADDRESS <i>RFD</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>				d. STREET ADDRESS <i>1 Cannon</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Alexander</i>	Middle <i>C.</i>	Last <i>Cannon</i>	4. DATE OF DEATH <i>March 26 1958</i>	Month <i>March</i>	Day <i>26</i>	Year <i>1958</i>
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>NEGRO</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>ABout 1883</i>	9. AGE (In years less birthday) <i>ABout 75</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>DAY LABORER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>FARM</i>		11. BIRTHPLACE (State or foreign country) <i>DORCHESTER CO. MD.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>UNKNOWN</i>				14. MOTHER'S MAIDEN NAME <i>LEAR NEAL</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>221-14-3809</i>		17. INFORMANT <i>WILLIAM H. NEAL, NEW CASTLE, DEL.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>002X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <i>Pulmonary Tuberculosis</i> <i>Unknown</i>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Malnutrition; Advanced Arteriosclerosis</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>3/20/58</i>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Salisbury Md.</i>		20f. (City or town) <i>Salisbury</i>	(County) <i>Wicomico</i> (State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>3/20</i> , 19 <i>58</i> , to <i>3/26</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>19</i> , and that death occurred at <i>5:15 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Salisbury Md.</i> DATE SIGNED <i>3/26/58</i>							
ACTUAL SIGNATURE <i>David L. Silcox</i>		M.D.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>MARCH 28 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>RHODESDALE CEMETERY</i>		22d. LOCATION (City, town, or county) <i>RHODESDALE, MARYLAND</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.W. PRAMPTON & SON</i>		ADDRESS <i>FEDERALSBURG MD.</i>		24a. REC'D BY REGISTRAR <i>MAR 31 '58</i>		24b. REGISTRAR'S SIGNATURE <i>John E. Smith</i>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y.

MR 31 1958

REFUGEE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3899

CERTIFICATE OF DEATH

03885

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 49 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Price, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First John	Middle Tucker	Last Carter	4. DATE OF DEATH	Month March	Day 19th, 1958	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1884	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 3	Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John H. Carter				14. MOTHER'S MAIDEN NAME Helen A. Kennard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unk.		16. SOCIAL SECURITY NO 207-01-8068		17. INFORMANT Deer's Head Hospital Records, Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor pulmonale				INTERVAL BETWEEN ONSET AND DEATH ?			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Emphysema DUE TO DUE TO (c)				Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Deer's Head State Hospital		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 29, 1958 , to March 19, 1958 , that I last saw the deceased alive on March 19, 1958 , and that death occurred at 10:40A.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Deer's Head State Hospital							
DATE SIGNED 3/19/58							
ACTUAL SIGNATURE <i>G. Kosmahly</i>		M.D. Deer's Head State Hospital					
PHYSICIAN'S NAME (Type) G. Kosmahly, M.D.		Salsbury, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 22		22c. NAME OF CEMETERY OR CREMATORIUM Church Hill		22d. LOCATION (City, town, or county) (State) Church Hill, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar L. Lane</i>		ADDRESS Church Hill, Md.					
		24a. REG'D BY REGISTRAR MAR 24 1958					
		24b. REGISTRAR'S SIGNATURE <i>Edgar L. Lane</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NO. 1 1059

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03886

**FOR STATE
HEALTH DEPT.**

TO **DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained by our files.
10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY		39-10				Reg. Dist. No.	
Wicomico		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		o STATE Maryland		b. COUNTY Wicomico	
Salisbury		12		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Pen. Gen. Hospital		Baker St					
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day Year
JOHN					MARCH		31 st 19 58
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Hours M.n.
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	March 1, 1895	63 yrs	0	30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret'd.)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Employee of Baking Co.				Scotland		U S A	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Timothy Christie		Anne Reynolds					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT		18. INTERVAL BETWEEN ONSET AND DEATH	
Unk				Mrs. Hannah C. Jones (Sister) 512 Scotland St. Williamsburg, Virginia		See below	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Frocture		Curved spine			
8/2 X		DUE TO					
Conditions, if any, which gave rise to immediate cause (b)							
(c)		DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Struck by auto crossing at 13							
20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
Hour 8:04 p.m.		3 31 1958	While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	Street	Salisbury	Wicomico	Md
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Earl L. Royer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED April 2 1958	
EXAMINER'S NAME (Type) Dr. Earl L. Royer							
22b. BURIAL CREMATION REMOVAL (Specify)		22c. DATE THEREOF		22d. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
Burial		Apr. 5, 1958		Wicomico Memorial Park		Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
HOLLOWAY & COMPANY		SALISBURY MARYLAND		APR 8 '58		<i>R. L. Royer</i>	
VS. AT 5ME SM 2-57				DATE			

BUREAU V. S

DR 8 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3975 CERTIFICATE OF DEATH

Reg. Dist. No.

03887

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.#		d. STREET ADDRESS R.D.#		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First RUTH	Middle HELEN	Last CLARK	4. DATE OF DEATH March 9th 1958	Month MARCH	Day 9th	Year 1958
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 25, 1904	9. AGE (In years last birthday) 53 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Wicomico Co. Pittsville Md		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles H. Esham				14. MOTHER'S MAIDEN NAME Nettie Lowe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO (If yes, give war or date of service)		17. INFORMANT Mr. Wallace D. Clark (Husband)		Address Pittsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)				DUE TO Acute coronary occlusion INTERVAL BETWEEN ONSET AND DEATH 5 minutes			
DUE TO Coronary artery sclerosis INTERVAL BETWEEN ONSET AND DEATH 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1951 to March 1958 , that I last saw the deceased alive on 3/8 1958 , and that death occurred at 2:45 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Harry Mattax							
ADDRESS (Street, city or town, state) 711 Camden Ave., Salisbury, Md DATE SIGNED 3/10/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 12, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Pittsville Cemetery		22d. LOCATION (City, town, or county) Pittsville, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLYWAY & COMPANY - SALISBURY, MARYLAND				ADDRESS 1201 W. Market St., Suite 100, Salisbury, Md		24a. REGISTRAR REGISTRAR DATE 3/10/58	
						24b. REGISTRAR'S SIGNATURE Albert J. Edie	

BUREAU V. S.
RECEIVED
MAR 14 1933

1

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please exercise the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and is any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03888

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Wicomico MARYLAND		Salisbury				a. STATE Maryland b. COUNTY Wicomico	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS		f. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
839 Cooper St		839 Cooper St					
3. NAME OF DECEASED (Type or print)	First EDNA	Middle MARY	Last CROCKETT	4. DATE OF DEATH	Month MARCH	Day 7th	Year 1958
5. SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 14, 1911	9 AGE (In years last birthday) 47 yrs	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS Days 23	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
House Work at Home		(Shirt Factory)		Salisbury, Maryland		U S A	
13. FATHER'S NAME John Emory Elliott		14. MOTHER'S MAIDEN NAME Lucinda C. Mitchell					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Donald Mayers (Daughter) Address Phila. Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute alcoholism		INTERVAL BETWEEN ONSET AND DEATH Sudden	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)					
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20e. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)		20f. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		Decedent was found dead lying on hot floor radiator		Home			
20c. TIME OF INJURY Hour p. m.	Month, Day, Year 19	20d. INJURY OCCURRED at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Salisbury	(County) Wicomico	(State) Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Earl L. Royer</i>		Dr. Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED March 10 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Mar. 11, 1958		22b. DATE THEREOF Mar. 11, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Spring Hill Mem. Gardens-R.D. Salisbury, Maryland		22d. LOCATION (City, town, or county) (State)	
23 FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND		ADDRESS		24a. REC'D BY REGISTRAR MAR 12 '58		24b. REGISTRAR'S SIGNATURE <i>Asheach</i>	

RECEIVED
BUREAU V.

APR 12 1959

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03889

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Wicomico</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>PENINSULA General Hospital</i>		d. STREET ADDRESS <i>675 West Main St</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>James</i>	Middle <i>Dashiel</i>	Last	4. DATE OF DEATH <i>March 10 1958</i>	Month	Day	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>1878</i>	9. AGE (In years last birthday) <i>80 yrs</i>	IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>TAXI</i>		11. BIRTHPLACE (State or foreign country) <i>MT Vernon</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. ?		17. INFORMANT <i>Etha Bixley 74y.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }		Arteriosclerosis, Heart Disease, Hypertension		INTERVAL BETWEEN ONSET AND DEATH			
(b) DUE TO C		Generalized Arteriosclerosis, definite					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. st. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <i>662 W Main</i>		20f. (City or town) (County) (State) <i>Salisbury, MD</i>	
21. I certify that I attended the deceased from <i>1 Mar 1957</i> to <i>12 Mar 1958</i> , that I last saw the deceased alive on <i>11 Mar 1958</i> , and that death occurred at <i>12 Mar 1958</i> , M, from the causes and on the date stated above.							
ACTUAL		M.D.		ADDRESS (Street, city or town, state) <i>Salisbury, MD</i>		DATE SIGNED <i>12 Mar 1958</i>	
PHYSICIAN'S NAME (Type) <i>E.A. PHIRNELL</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-14-58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>MT Vernon Cemetery</i>		22d. LOCATION (City, town, or county) <i>MT Vernon Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Blakesley W. Bush</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>Mar 19 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Act. eam</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SURNAME

MAR 19 1958

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1

**FOR STATE
HEALTH DEPT.**

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO MEDIICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained by files.

VS. A15ME
SM. 2.57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03890

Reg. Dist. No.

1. PLACE OF DEATH		3913		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
e. COUNTY		Wicomico		b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN Tb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Salisbury				12 Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS	
Peninsula General Hospital					
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	
Arlene				Lost	Month Day Year
5. SEX		6 COLOR OR RACE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	
F		C	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	16-22-57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
None		None		9 Months	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		10. IF UNDER 1 YEAR Months Days Hours Min.	
Peter Davis		Elveta Bockley		11. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		12. IF UNDER 24 HRS USA.	
(If yes, give war or dates of service)		17. INFORMANT			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		Acute gastroenteritis			
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)					
511.0 DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEAS CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Earl L. Roger</i>		DATE SIGNED 3-26-58			
EXAMINER'S NAME (Type) Earl L. Roger		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION (REMOVALS Specify) Burial		22b. DATE THEREOF 3-24-58		22c. NAME OF CEMETERY OR CREMATORIAL Mt Calvary Cem	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Booker M. West</i>		ADDRESS 3448 E. 34th St.		22d. LOCATION (City, town, or county) Frederick	
				24a. REC'D BY REGISTRAR MAR 28 '58	
				24b. REGISTRAR'S SIGNATURE <i>W. J. Deane</i>	

BUREAU Y.

MAR 28 1958

DEGELVÉO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3994

CERTIFICATE OF DEATH

03891

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula Gen. Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Scott	Middle C	Last Davis		
4. DATE OF DEATH	Month 3	Month 8	Day Year 1958		
5. SEX Male	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 17 1901		
9. AGE (In years lost birthday) 57 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James Davis		14. MOTHER'S MAIDEN NAME Rachel Purnell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-28-3682	17. INFORMANT Mrs. Katie Davis, Berlin, Md., Rt # 2 Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Diabetes Acidosis</i>		INTERVAL BETWEEN ONSET AND DEATH 12 hrs.			
X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Diabetes Mellitus</i>		DUE TO (c) <i>Vitroesclorosis (Cardiovascular Disease)</i> ≥ 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Berlin	(County) Maryland	(State)
21. I certify that I attended the deceased from 3/7, 1958, to 3/8, 1958, that I last saw the deceased alive on 3/8, 1958, and that death occurred at 9 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Rufus G. Gardner Jr.</i> ADDRESS (Street, city or town, state) <i>Salisbury, Md.</i> DATE SIGNED <i>3/12/58</i> PHYSICIAN'S NAME (Type) <i>Pine Bluff Rd. S. (RUFUS G. GARDNER, JR.)</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/11/1958	22c. NAME OF CEMETERY OR CREMATORIUM Evergreen Cemetery	22d. LOCATION (City, town, or county) Berlin, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.			24a. REC'D BY REGISTRAR DATE MAR 13 '58	24b. REGISTRAR'S SIGNATURE <i>G. L. Smith</i>	

REGIAE
BUREAU V. S.

Aug 29 1938

BUREAU Y.

MAR. 15, 1928

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3976

CERTIFICATE OF DEATH

03593

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico County</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural and give nearest town</i>	c. LENGTH OF STAY IN lb <i>10 yrs</i>	b. COUNTY <i>Wicomico</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Salisbury</i>	d. STREET ADDRESS <i>Collins St.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Otis</i>	First <i>Otis</i>	Middle <i>Downes</i>	Last <i>Downes</i>				
4. SEX <i>M</i>	5. COLOR OR RACE <i>C</i>	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>1895</i>	8. AGE (In years, last birthday) <i>63</i>	9. IF UNDER 1 YEAR Months <i>3</i>	10. IF UNDER 24 HRS. Days <i>19</i>	11. Year <i>1958</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Centerville Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Downes</i>		14. MOTHER'S MAIDEN NAME <i>Florence Martin</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Wife</i>		16. SOCIAL SECURITY NO. <i>214-12-6514</i>		17. INFORMANT <i>Mattie Downes</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i>		(b) <i>Pneumonia, Teremia</i>		(c) <i>Gonococcal intercardiosis, bronchopneumonia</i>		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D.</i>		20f. (City or town) <i>Centerville</i>	(County) <i>Wicomico</i>
21. I certify that I attended the deceased from <i>6-6-58</i> , to <i>16-3-58</i> , that I last saw the deceased alive on <i>19-3-58</i> , and that death occurred at <i>16-3-58</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>E. Purnell</i>		ADDRESS (Street, city or town, state) <i>652-671 Main St.</i>					
PHYSICIAN'S NAME (Type) <i>E. A. Purnell, M.D.</i>		DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-22-58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Centerville Cem.</i>		22d. LOCATION (City, town, or county) <i>Centerville Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Booker M. West.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>MAR 2 8 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. E. Rose</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REF ID: A11245
MAR 1998

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be retained by the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3917 CERTIFICATE OF DEATH

Reg. Dist. No. 03894

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City		d. STREET ADDRESS R.F.D.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William H. Fisher		First	Middle	Last	4. DATE OF DEATH March 29 1958	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 9, 1900	9. AGE (In years last birthday) 37 yrs.	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FISHING-SHIPPER		10b. KIND OF BUSINESS OR INDUSTRY OWN BUSINESS		11. BIRTHPLACE (State or foreign country) Ocean City Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME WILLIAM THOMAS ELLIOTT Sr		14. MOTHER'S MAIDEN NAME EDNA BEAUCHAMP							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes W.W.II VETERAN		16. SOCIAL SECURITY NO.		17. INFORMANT Max W.L. Elliott Jr., Ocean City Md		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema		DUE TO 157x		INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) DUE TO Pulmonary carcinomatosis							
(c) DUE TO Carcinoma of pancreas metastases				4 months					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, M, from the causes and on the date stated above.									
ACTUAL SIGNATURE William H. Fisher		NAME (Type) W.H. Fisher		ADDRESS Salisbury Md.		DATE SIGNED Mar. -		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/31/58		22c. NAME OF CEMETERY OR CREMATORIAL EVERGREEN		22d. LOCATION (City, town, or county) Baltimore		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hannah A. Birbage		ADDRESS Baltimore Md.		24a. REC'D BY REGISTRAR APR 2 51		24b. REGISTRAR'S SIGNATURE On Health		DATE	

BUREAU V. S.

APR 2 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03895

1. PLACE OF DEATH a. COUNTY		Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 842 West Main St				d. STREET ADDRESS 842 W. Main St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MARY	Middle RUTH	Last ELLIS	4. DATE OF DEATH	MARCH	Month 4th	Day Year 19 58
S SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Single	8. DATE OF BIRTH May 31, 1897	9. AGE (In years less birthday) 60 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Albert Purnell Ellis			14. MOTHER'S MAIDEN NAME Rebecca Flemming				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO V MANT Mrs. Oda M. Heath (Sister) 842 W. Main St. Salisbury, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 440.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Hypertensive Cardiac disease DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 11 min							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month. Doy. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1951, 19, to 1958, 19, that I last saw the deceased alive on 3/4/58, 19, and that death occurred at 11:30 AM, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)							
ACTUAL SIGNATURE Alberta Mattax M.D. 711 Camden Ave 3/16/58							
DATE SIGNED							
PHYSICIAN'S NAME (Type) Dr. Alberta Mattax		711 Camden Ave. Salisbury, Md. Mar. 158					
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 7, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND				24a. REC'D BY REGISTRAR DATE MAR 10 '58		24b. REGISTRAR'S SIGNATURE G. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU U. S.

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3976

CERTIFICATE OF DEATH

Reg. Dist. No.

03896

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanticoke		c. LENGTH OF STAY IN lb Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X Nanticoke	
3. NAME OF DECEASED (Type or print) JOHN T. ELSEY		First JOHN	Middle T.
4. DATE OF DEATH Mar. 19	Last ELSEY	Month Mar.	Day 19
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/12/91
9. AGE (In years lost birthday) 66 yrs.	10. IF UNDER 1 YEAR 9 Months	11. IF UNDER 24 HRS. 7 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fishing	10b. KIND OF BUSINESS OR INDUSTRY Oyster tonger	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY U.S.
13. FATHER'S NAME John James Elsey		14. MOTHER'S MAIDEN NAME Sally ----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Essie Elsey, Nanticoke, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
<i>Cerebral Hemorrhage.</i> 48 hours <i>Generalized Arteriosclerosis.</i> 10 years			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour O. M. 19 P. M.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 15 Jelley, 1947 to 19 March 1958 that I last saw the deceased alive on 19 March, 1958 , and that death occurred at 6 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard H. Saunders, M.D.		ADDRESS (Street, city or town, state) Nanticoke Md. DATE SIGNED 3/21/58	
PHYSICIAN'S NAME (Type) Richard H. Saunders		Nanticoke, Maryland 3/21/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/23/58	
22c. NAME OF CEMETERY OR CREMATORIUM Nanticoke Cem.		22d. LOCATION (City, town, or county) (State) Nanticoke, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Amelia J. Jeschik		ADDRESS Bivalve, Maryland	
		24a. REC'D BY REGISTRAR DATE MAR 28 '58	
		24b. REGISTRAR'S SIGNATURE Bill Smith	

ELVÉ

1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03897

3919

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) d. STATE <i>Maryland</i>		b. COUNTY <i>Wicomico</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>RURAL and give nearest town</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		d. STREET ADDRESS <i>295 Lincoln Ave.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Ernest</i>	Middle <i>EDWARD</i>	Last <i>ENNIS</i>	4. DATE OF DEATH <i>March 18</i>	Month <i>March</i>	Day <i>18</i>	Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Feb. 28, 1878</i>	9. AGE (In years (at birthday) yrs.) <i>80</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		11. BIRTHPLACE (State or foreign country) <i>Salisbury, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>		
13. FATHER'S NAME <i>William Ennis</i>			14. MOTHER'S MAIDEN NAME <i>Rachel Murphy</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unk</i>			16. SOCIAL SECURITY NO.			17. INFORMANT <i>Mrs. Stella Soloway (Daughter) ADD: Snow Hill Maryland</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>suicide</i> 442.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>degenerative - heart disease</i> (c) <i>5 yrs.</i>								
INTERVAL BETWEEN ONSET AND DEATH <i>100 hr.</i>								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>Mar. 17, 1958</i> to <i>Mar. 18, 1958</i> , that I last saw the deceased alive on <i>Mar. 17, 1958</i> , and that death occurred at <i>Salisbury</i> M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Dr. Earl Beardsley</i> M.D. ADDRESS (Street, city or town, state) <i>Salisbury Md.</i> DATE SIGNED <i>5/18/58</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Feb. 20, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Wicomico Memorial Park</i>		22d. LOCATION (City, town, or county) (State) <i>Salisbury, Maryland</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>HOLLOWAY & COMPANY - SALISBURY MARYLAND</i>			ADDRESS <i>Holloway & Company - Salisbury Maryland</i>			24a. REC'D BY REGISTRAR DATE <i>Mar 19 '58</i>		
						24b. REGISTRAR'S SIGNATURE <i>Debby</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

URÉAU V. S.

MAR 19 1973

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3910

Item 751-14-14-b1 et

CERTIFICATE OF DEATH

Reg. Dist. No.

03898

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Wicomico				a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
SALISBURY				SALISBURY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
TOWNSHIP GENERAL HOSPITAL		213 SHADPOINT ROAD			
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH
GEORGE				ENNIS	MARCH 31 1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) yrs
Male		WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb 7 1882	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired Farmer				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY	
Henry S. Ennis		Sarah Maddox		U.S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no		814-25-8605		Lenson Lawson 76 Garage Ave Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Hemorrhage 16 hrs			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Pneumonia, Asthma, etc. 10 days			
(b)					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Hypertension, heart disease					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that I attended the deceased from 3/30/1958 to 3/31/1958, that I last saw the deceased alive on 3/31/1958, and that death occurred at 2:30 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE		M.D. 111 East Boundary St. 3/31/1958			
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM	
Burial 4/2/58				Salem Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
Knox Freeman		ADDRESS		24b. REGISTRAR'S SIGNATURE	
				DATE APR 7 '58	

SUREAU V. S.

APR 7 1963

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate should be detached for use as a burial transit permit.

VS AISC 1-510W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03899

3931 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	...Wicomico	MARYLAND	STATE
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Length of Stay (in this place)	TOWN	Maryland COUNTY ...Wicomico
TOWN	Since 1/0/58	X	CITY (If outside corporate limits, write RURAL and give nearest town)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Pine Bluff State Hospital Salisbury, Maryland	STREET ADDRESS	TOWN
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH March 27 1958	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Male	White	Widowed	August 31, 1887
9. AGE last birthday	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	
70 yrs.	70	Hours Min.	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Farmer		Farming	Mt. Herman Road Wicomico County
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Joseph James Ennis		Sarah White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT & ADDRESS Mrs. Irene Gordy Records of Pine Hill	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
7. IMMEDIATE CAUSE (A) Cardiac decompensation		6 mos.	
ANTECEDENT CAUSE(S) DUE TO		2 yrs.	
DISEASES OR CONDITIONS, IF ANY, (B) giving rise to the above cause STATING UNDERLYING CAUSE LAST. DUE TO		Obstructive Pulmonary Emphysema	
(C)		8 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		(State)	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from January 6, 1958, to March 27, 1958, that I last saw the deceased alive on March 27, 1958, and that death occurred at 2:27 P.M. from the causes and on the date stated above. SIGNATURE <i>Edward P. Ritchings</i> M.D. ADDRESS (Street, city, town, state) <i>Salisbury, Maryland</i> DATE SIGNED <i>3/27/58</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Mar. 30, 1958	NAME OF CEMETERY OR CREMATORIAL Parsonsburg Cemetery
LOCATION (City, town, or county) Parsonsburg, Maryland		(State)	
24. REC'D BY REGISTRAR DATE 3/58		REGISTRAR'S SIGNATURE <i>Calderon</i>	25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MD.
ADDRESS			

BUREAU V. S.

82 1 2 28
1900

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3912

CERTIFICATE OF DEATH

03900

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WICOMICO		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE DELAWARE		b. COUNTY SUSSEX		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DELMAR		d. STREET ADDRESS LINCOLN AVE		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA General HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Cora		First	Middle	Last	4. DATE OF DEATH MARCH 9, 1958	Month	Day	Year
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4-2-1874	9. AGE (In years last birthday) 83	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Jerry Wix		14. MOTHER'S MAIDEN NAME unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Done James Faulkner, Son, tel		Address in advance		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Degenerative heart disease.						INTERVAL BETWEEN ONSET AND DEATH in advance		
4. D. D. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO (c)						
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from March 17, 1958 , to March 9, 1958 , that I last saw the deceased alive on MARCH 9, 1958 , and that death occurred at 10 P.M. , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Salisbury, Md		DATE SIGNED 3-11-58
ACTUAL SIGNATURE William J. Ellsworth		M.D.						
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-58		22c. NAME OF CEMETERY OR CREMATORIAL Odd Fellows		22d. LOCATION (City, town, or county) Camden, Del		(Side)
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Maryland Co - Selby, Del		ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 13 '58		24b. REGISTRAR'S SIGNATURE W. E. Smith		

BUREAU V. S.

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PERIODICAL

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03901

3813 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	c. LENGTH OF STAY IN 1b 18 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS ---	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Jennie	Middle A.	Last Foster
4. DATE OF DEATH	Month March	Day 10,	Year 19 58
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1865
9. AGE (In years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Archie Miller		14. MOTHER'S MAIDEN NAME Susan Skinner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO ---	
17. INFORMANT Deer's Head Hospital Records, Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis, generalized		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 20, 19 58, to March 10, 19 58, that I last saw the deceased alive on March 10, 19 58, and that death occurred at 7:35 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE L. V. Maldve, M.D. PHYSICIAN'S NAME (Type)			
ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 3/11/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF March 12 - 58	
22c. NAME OF CEMETERY OR CREMATORIUM Cambridge Valley		22d. LOCATION (City, town, or county) (State) Cambridge New York	
23. FUNERAL DIRECTOR'S SIGNATURE E. Brown & Sons Funeral Home		ADDRESS Centreville Maryland	
24a. REC'D BY REGISTRAR DATE MAR 13 '58		24b. REGISTRAR'S SIGNATURE John Doe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.
PARIS
PARIS 13 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3914 CERTIFICATE OF DEATH

Reg. Dist. No.

03902

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		e. STREET ADDRESS R.D.# 1		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EDNA ELIZABETH GODWIN		First	Middle	Last	4. DATE OF DEATH MARCH 27 th 1958	Month	Day Year
5. SEX Female		6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 14, 1907	9. AGE (In years last birthday) 50 yrs.	10. IF UNDER 1 YEAR Months 9 Days 13	11. IF UNDER 24 HRS Hours 13 Min
10a. USUAL OCCUPATION (Give kind of work done during regular working time, even if retired) Operator at Shirt Factory		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Sussex Co. Delaware		12. CITIZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME Henry Godwin		14. MOTHER'S MAIDEN NAME Ida Elizabeth Figgs					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Reuben Watson Jr. R.D. # 5 Address Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cancer of Cervix		INTERVAL BETWEEN ONSET AND DEATH 9 mos. after			
17/IX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO		Diagnosis made			
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1957 to March 1958, that I last saw the deceased alive on March 26, 1958, and their death occurred at 3 AM, from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE James P. Gallaher, M.D.				Medical Center, Salisbury, Md.			
PHYSICIAN'S NAME (Type) Dr. Jas. P. Gallaher				Medical Center, Salisbury, Md.		Mar. 28/158	
22a. BURIAL, CREMATION, REMOVAL, ETC. Burial		22b. DATE THEREOF Mar. 29, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park		22d. LOCATION (City, town, or county) Salisbury, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE APR 3 '58		24b. REGISTRAR'S SIGNATURE Quinn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU X

APR 3 1958

JOHNSON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3977

CERTIFICATE OF DEATH

Reg. Dist. No.

13903

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs		c. LENGTH OF STAY IN 1b 25 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First John	Middle O.	Last Hall	4. DATE OF DEATH Month Mar	Day 8	Year 1958		
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1887	9. AGE (In years from birthday) 70 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME Albert Hall			14. MOTHER'S MAIDEN NAME Matilda Moore					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO 215-26-4070		17. INFORMANT Essie Hall, Mardela Springs, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 794x DUE TO general debility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO fracture decline (c) days hence - Mar 6th								
19. INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Mar 3rd, 1958 to Mar 6th, 1958 , that I last saw the deceased alive on Mar 5th, 1958 , and that death occurred at M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Essie Hall, Mardela Springs, Md. DATE SIGNED Mar 6th, 1958								
ACTUAL SIGNATURE George Seelye, M.D.								
PHYSICIAN'S NAME (Type) George Seelye, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-58		22c. NAME OF CEMETERY OR CREMATORIUM Stevens Field		22d. LOCATION (City, town, or county) Wetipquin, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Marvel, Shadytop, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 14 '58		24b. REGISTRAR'S SIGNATURE Albert Seelye		

BUREAU V. S

MAR 14 1959



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3915

CERTIFICATE OF DEATH

03904

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico Co.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>WORCESTER</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. LENGTH OF STAY IN 1b <i>2645</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pocomoke City</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>PE-NINSULA GENERAL HOSPITAL</i>		d. STREET ADDRESS <i>R.R. 2</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF <i>LESLIE</i> (Type or print)	First <i>I.</i>	Middle <i>HALL</i>	Last	4. DATE OF DEATH <i>MARCH 14 1958</i>	Month	Day	Year
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>FEB. 18-1902</i>	9. AGE (in years last birthday) <i>56 yrs</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SANDING & REFINISHING</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>FLOORING</i>		11. BIRTHPLACE (State or foreign country) <i>VIRGINIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>THOMAS HALL</i>		14. MOTHER'S MAIDEN NAME <i>ELLA L. TATMAN</i>		Address <i>220-32-9354 MRS CARYLEE HALL, POCOMOKE CITY, MD.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Vol. no. or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Artery Thrombosis</i>		DUE TO <i>Coronary Artery Thrombosis</i>		(b) <i>Coronary Atherosclerosis</i>		(c)	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>HALLWOOD, VIRGINIA</i>		20f. (City or town) (County) <i>HALLWOOD</i> (State) <i>VIRGINIA</i>	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 6:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>David J. Watson</i>		ADDRESS <i>Pocomoke, MD.</i>		ADDRESS (Street, city or town, state) <i>Pocomoke, MD.</i>		DATE SIGNED <i>Mar 14, 1958</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>MARCH 16 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>GROTON CEMETERY</i>		22d. LOCATION (City, town, or county) <i>HALLWOOD, VIRGINIA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry S. Watson</i>		ADDRESS <i>Pocomoke, MD.</i>		24a. REC'D BY REGISTRAR DATE <i>Mar 18 58</i>		24b. REGISTRAR'S SIGNATURE <i>Dale Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that this death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y.

MAR 18 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3916

CERTIFICATE OF DEATH

Reg. Dist. No.

03905

1. PLACE OF DEATH a. COUNTY		Wicomico MARYLAND	2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Salisbury	c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Pen. Gen. Hospital	d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
e. FIRST MIDDLE LAST		SOPHIA BELINDA HALL	4. DATE OF DEATH	Month March	Day 11th	Year 1958	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days Hours Min		
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	May 15, 1872	85			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
House work		None	Wayland New York		U S A		
13. FATHER'S NAME ----- Wolfanger			14. MOTHER'S MAIDEN NAME No Record				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO	17. INFORMANT Mrs. Anna Barry (Daughter) 803 E. William St Salisbury, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		Cerebral hemorrhage				INTERVAL BETWEEN ONSET AND DEATH Always.	
442x Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		Atherosclerotic hypertensive cardio vascular disease				4 years.	
DUE TO (b)							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDEPLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>4/18</u> , 19 <u>57</u> to <u>1/27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/27</u> , 19 <u>58</u> , and that death occurred at <u>3:15 AM</u> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state)	DATE SIGNED
ACTUAL SIGNATURE <i>Dr. Andrew J. Mitchell</i> PHYSICIAN'S NAME (Type) <i>Dr. O.J. Burton</i>						M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 15, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery	22d LOCATION (City, town, or county) Salisbury, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND		ADDRESS HOLLOWAY & COMPANY - SALISBURY MARYLAND	24a. REC'D BY REGISTRAR DATE MAR 14 '58	24b. REGISTRAR'S SIGNATURE <i>G. L. Smith</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGELIA FED

MAR 14 1958

BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3917 CERTIFICATE OF DEATH

Reg. Dist. No.

039116

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u>		b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GIRDLETREE</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <u>NELLIE</u>	Middle <u>R.</u>	Last <u>Hancock</u>	4. DATE OF DEATH <u>MARCH 14 1958</u>	Month	Day	Year
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 23-1882</u>	9. AGE (In years lost birthday) <u>76 yrs.</u>	IF UNDER 1 YEAR Months <u>0</u>	Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hausfrau</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Girdletree, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>Girdletree, Md</u>	
13. FATHER'S NAME <u>James W. Redden</u>		14. MOTHER'S MAIDEN NAME <u>Betty A. Mitchell</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Silas S. Hancock, Girdletree, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Myocardial Insufficiency</u> (c) <u>Atherosclerotic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Hour a. m. p. m.	Month <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	20f. (City or town) <u>Girdletree</u>	(County) <u>Wicomico</u>	(State) <u>Md</u>	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____ A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>March 14, 1958</u>							
ACTUAL SIGNATURE <u>Silas S. Hancock</u>		PHYSICIAN'S NAME (Type) <u>Dr. Edward J. Schlueter</u>					
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 16/58</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Girdletree, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clay O. Dennis</u>		ADDRESS <u>Salisbury, Md</u>		24a. REC'D BY REGISTRAR <u>None</u>		24b. REGISTRAR'S SIGNATURE <u>None</u>	
VS A15 (4) 15M 9/55		DATE <u>Mar 18 '58</u>					

BUREAU V.

MAR 15 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03908

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WICOMICO		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEALISBURY		c. LENGTH OF STAY IN lb 10 D 745		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL		d. STREET ADDRESS R R #2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First HETTIE	Middle MARGARET	Last HASTINGS	4. DATE OF DEATH MARCH 23 1958	Month Day Year		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 2, 1883	9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) BERLIN MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM JARVIS		14. MOTHER'S MAIDEN NAME SARAH BOWEN					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mr. GEORGE E. HASTINGS Berlin MD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 465x		DUE TO Pulmonary infarction		INTERVAL BETWEEN ONSET AND DEATH 1 day.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/23 1958 , to 3/23 1958 , that I last saw the deceased alive on 3/23 1958 , and that death occurred at 8 PM , from the causes and on the date stated above. ACTUAL TIME Refus S. Gardner Jr.		ADDRESS (Street, city or town, state) Refus S. GARDNER JR., Berlin, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/27/58		22c. NAME OF CEMETERY OR CREMATORIUM EVERGREEN		22d. LOCATION (City, town, or county) BERLIN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Anna H. Durban Berlin Md		ADDRESS ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 31 58		24b. REGISTRAR'S SIGNATURE Debrauch	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL: OR: After this certificate has been signed by the attending physician and completely filled in by one funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3918 CERTIFICATE OF DEATH

Reg. Dist. No 3907

1. PLACE OF DEATH a. COUNTY WICOMICO		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY WICOMICO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b 7 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		d. STREET ADDRESS 325 Elmwood St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JOHN	Middle E	Last HASTINGS	4. DATE OF DEATH MARCH 7 1958	Month MARCH	Day 7	Year 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 17, 1873	9. AGE (In years lost at birthday) yrs 84	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS Hours 20	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Melsons, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph Hastings		14. MOTHER'S MAIDEN NAME Harriett Ellen Hall					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Granville Jones (Daughter)		Address 1114 East Church St. Salisbury, Maryland	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver		DUE TO Alcoholism		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Sensitivity		DUE TO ?					
(c) ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above. ACTUAL SIGNATURE R. C. Mitchell		ADDRESS (Street, city or town, state) Parsons Cemetery M.D.					
PHYSICIAN'S NAME (Type) Dr. Andrew C. Mitchell		DATE SIGNED Mar. 7th, 1958					
22a. BURIAL, CREMATION, REMOVAL IS REQUESTED Burial		22b. DATE THEREOF Mar. 9, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND		ADDRESS 123 Main Street, Salisbury, Maryland		24a. REC'D BY REGISTRAR Mar. 10, 1958		24b. REGISTRAR'S SIGNATURE John C. Clegg	

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PUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3920 CERTIFICATE OF DEATH

03909

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>WORCESTER</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>OCEAN CITY</i>		d. STREET ADDRESS <i>R.R. 3</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>PENINSULA GENERAL HOSPITAL</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>LIPSHUR</i>		First	Middle	Last	4. DATE OF DEATH <i>HENRY</i>	Month	Day	Year	
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>COLORED</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>October 12, 1910</i>	9. AGE (In years lost birthday) <i>47 yrs.</i>	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	11. IF UNDER 24 HRS Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Restaurant</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>SPENCER Pitts</i>		14. MOTHER'S MAIDEN NAME <i>Charlotte E. Henry</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-03-5910</i>		17. INFORMANT <i>Mrs. Charlotte Purnell, Berlin, Md., R# 3</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Lymphocytic Leukemia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>							
600.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. {		DUE TO (b) DUE TO (c)	Chronic Lymphocytic Leukemia (Cerebral involvement) 8 yrs						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>112 S. 1st Street</i>		20f. (City or town) <i>Berlin</i>		(County) <i>Wicomico</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>12/28/57</i> , 1957, to <i>1/2/58</i> , 1958, that I last saw the deceased alive on <i>12/28/57</i> , 1957, and that death occurred at <i>112 S. 1st Street</i> , Berlin, Md., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>112 S. 1st Street, Berlin, Md.</i>							DATE SIGNED <i>4-1-58</i>
ACTUAL SIGNATURE <i>John J. Scamone</i>		M.D.							
PHYSICIAN'S NAME (Type) <i>John J. Scamone</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>4-1-58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>EVERGREEN Cemetery</i>		22d. LOCATION (City, town, or county) <i>Berlin, Md.</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.F. Stewart Funeral Home, Salisbury, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>APR 2 '58</i>		24b. REGISTRAR'S SIGNATURE <i>John J. Scamone</i>			
VS A15 (4) 15M 9/55									

BUREAU V.

APR 2 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3921

CERTIFICATE OF DEATH

Reg. Dist. No.

13910

1. PLACE OF DEATH
a. COUNTY

Wicomico

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Salisbury

c. LENGTH OF STAY IN lb

4 WEEKS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Worcester

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Pocomoke City

d. STREET ADDRESS

1503 MARKET STREET

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)

Fannie

First

Middle

Last

4. DATE
OF
DEATH

March 11

1958

5. SEX

Female white

6. COLOR OR RACE

WIDOWED DIVORCED 7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

JAN. 10 1902

9. AGE (In years
less birthday)
56 yrs10. IF UNDER 1 YEAR
Months Dots Hours Min.11. IF UNDER 24 HRS.
Hours Min.10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

CLERK

10b. KIND OF BUSINESS OR INDUSTRY

MERCHANTILE

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

FLETCHER R. HICKMAN

14. MOTHER'S MAIDEN NAME

DAISY L. TAYLOR

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) [If yes, give war or dates of service]

NO

16. SOCIAL SECURITY NO.

213-05-5970

17. INFORMANT

Address

STEWART A. HICKMAN, POCOMOKE CITY, MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Carcinoma cervix epidermoid

/ X DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b) Stage IV

DUE TO

(c) Uterus due to 1 above

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, notify MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m.20d. INJURY OCCURRED
While at work Not while at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 2-11-1958 to 3-11-1958, that I last saw the deceased alive on 12, and that death occurred at 11 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Robert Lee Baker M.D.

3-12-58

PHYSICIAN'S
NAME (Type)

ROBERT LEE BAKER M.D. SALISBURY, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

3-13-58

22c. NAME OF CEMETERY OR CREMATORIUM

DOWNING CEMETERY

22d. LOCATION (City, town, or county)

OAK HALL, VIRGINIA

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Henry S. Watson

ADDRESS

POCOMOKE, MD.

24d. REC'D BY REGISTRAR

DATE MAR 17 '58

24b. REGISTRAR'S SIGNATURE

A. Deacon

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. I.

MAR 17 1959

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03911

3922

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS Woodland Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First LEONTINE	Middle IRENE	Last HIGGINS	4. DATE OF DEATH Month March	Day 5th	Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 23, 1906	9. AGE (In years last birthday) 51 yrs.	10. IF UNDER 1 YEAR Months 8	11. IF UNDER 24 HRS. Hours 12	12. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home (Retired Nurse)		10b. KIND OF BUSINESS OR INDUSTRY Cleveland, Ohio		11. BIRTHPLACE (State or foreign country) Cleveland, Ohio		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Pimsner		14. MOTHER'S MAIDEN NAME Anna Bodenlosz					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Dr. Raymond O Higgins (Husband) Address Woodland Road - Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Generalized Carcinomatosis				INTERVAL BETWEEN ONSET AND DEATH	
		Carcinoma of the Intestinal Tract					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION	20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
	20c TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November, 1956 , to March 5, 1958 that I last saw the deceased alive on March 5, 1958 , and that death occurred at 6:40 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE Thomas C. Hill		M.D.				DATE SIGNED	
PHYSICIAN'S NAME (Type) Dr. Thomas C. Hill		Salisbury, Maryland				Mar. 7 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Mar. 8, 1958		22b. DATE THEREOF Mar. 8, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND		ADDRESS MAR 10 1958		24a. REC'D BY REGISTRAR Alvarez		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please report carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

LIBRARY NO. 2
LAWRENCE

MAP Q 193

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

13912

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm P.M.3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a Burial-Transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico		4. 3923		2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb Pen. Gen. Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 114 E. Isabella St	
3. NAME OF DECEASED (Type or print) PERCY		First WILLIAM	Middle HOTTON	Lost 55	Date of DEATH MARCH 12th 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 4, 1902	9. AGE (In years last birthday) 55	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0 IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner & Operator of Kaye Venetian Blind Co. (England)		10b. KIND OF BUSINESS OR INDUSTRY Kaye Venetian Blind Co. (England)		11. BIRTHPLACE (State or foreign country) England	
13. FATHER'S NAME William P. Joseph Hotton		14. MOTHER'S MAIDEN NAME Henrietta Girard		12. CITIZEN OF WHAT COUNTRY? U S A	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Louise K. Hotton (Wife) 114 E. Isabella St., Salisbury, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a)		Cerebral edema		INTERVAL BETWEEN ONSET AND DEATH Sudden	
X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Coronary and cerebral arteriosclerosis		Years	
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
Fracture of sternum with mediastinal hemorrhage.					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Black out caused him to have head on collision.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 3-10- 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) Highway R F D 13	20f. (City or town) Salisbury	(County) Wicomico
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Earl L. Royer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED March 13 1958	
22a. BURIAL, CREMATION ON, DATE THEREOF REMOVAL (Specify) Burial Mar. 15/58		22c. NAME OF CEMETERY OR CREMATORIUM Wicomico Memorial Park		22d. LOCATION (City, town, or county) Salisbury, Maryland	
(State)					
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND		ADDRESS DAMAR 18 '58		24a. REC'D BY REGISTRAR Abraham	
24b. REGISTRAR'S SIGNATURE					

BUREAU Y. E

MAR 18 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3924 CERTIFICATE OF DEATH

Reg. Dist. No. 113913

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b 3 WEEKS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Luke's General Hospital.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City	
3. NAME OF DECEASED (Type or print) Catherine M. Howard		d. STREET ADDRESS 5 FRONT STREET	
4. DATE OF DEATH MARCH 3, 1958		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 12, 1886	
9. AGE (in years last birthday) 71 yrs.		10. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
10c. BIRTHPLACE (State or foreign country) MARYLAND		11. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME THOMAS R. MERRILL		14. MOTHER'S MAIDEN NAME HARRIET MILLS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE 17. INFORMANT CHARLES T. HOWARD, Pocomoke City, MD. Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of liver			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Pocomoke City (County) Wicomico (State) Maryland	
21. I certify that I attended the deceased from 3/3/58 to 3/3/58 , that I last saw the deceased alive on 3/3/58 , and that death occurred at 11 A.M. from the causes and on the date stated above.		ADDRESS (Street, city, town, state) Pine St. Buff Bldg., Pocomoke City, MD. DATE SIGNED 3/5/58	
ACTUAL SIGNATURE Rufus L. Anderson Jr.		PHYSICIAN'S NAME (Type) Henry H. Watson	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-5-58	
22c. NAME OF CEMETERY OR Crematory FIRST BAPTIST		22d. LOCATION (City, town, or county) Pocomoke City, Maryland (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson		ADDRESS Pocomoke, MD.	
24a. REC'D. BY REGISTRAR MARY 10, 1958		24b. REGISTRAR'S SIGNATURE John W. Brown	

RECEIVED
FEBRUARY V. S.

3 16 1953

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3925 CERTIFICATE OF DEATH

Reg. Dist. No.

03.014

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 6 Wks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1/2 Salisbury		d. STREET ADDRESS 109 Weldon Ave.,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium				d. STREET ADDRESS 109 Weldon Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mrs. Mary	Middle Burggraf	Last Hubbert	4. DATE OF DEATH	Month March	Day 3	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1886		9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Burggraf				14. MOTHER'S MAIDEN NAME Ann Wagner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Alvin C. Hubbert, Jr. Salisbury		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DISSEMINATED CARCINOMATOSIS				INTERVAL BETWEEN ONSET AND DEATH 6 months			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO CARCINOMA OF R. BREAST							
DUE TO (c) HYPERTENSIVE ATHEROSCLEROTIC CARDIACULAR DISEASE							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 3/19, 1958, to 2/21, 1958, at 10:40 AM					
20c. TIME OF INJURY Hour a. p.m.	Month 19	Doy	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D. Salisbury, Maryland	(County) (State)
21. I certify that I attended the deceased from 3/19, 1958 to 2/21, 1958 , and that death occurred at 10:40 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. Salisbury, Maryland DATE SIGNED 3/4/58							
ACTUAL SIGNATURE <i>O. J. Burton</i>		PHYSICIAN'S NAME (Type) O. J. Burton					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/5/58		22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery		22d. LOCATION (City, town, or county) Salisbury, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Md.		ADDRESS Norman T. Baker					
		24a. REC'D BY REGISTRAR Mar 6 '58					
		24b. REGISTRAR'S SIGNATURE W. E. Schuck					

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU X. S.
MCGEIVY

MAR 6 1963

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3926

CERTIFICATE OF DEATH

Reg. Dist. No. 03915

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 16 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Charles	Middle	Last Jackson	4. DATE OF DEATH March 13 1958	Month March	Day 13	Year 1958		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/12/1885	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Samuel Jackson		14. MOTHER'S MAIDEN NAME Henrietta Davis							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or Unknown) Unk.		16. SOCIAL SECURITY NO 214-32-5992A		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia						INTERVAL BETWEEN ONSET AND DEATH 7 days			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Multiple Sclerosis						?			
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive Arteriosclerotic Cardiovascular Disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Near Hurlock, Maryland		20f. (City or town) Deer's Head State Hospital		(County) Salisbury, Maryland	(State) MD
21. I certify that I attended the deceased from Nov. 27, 1956 , to March 13, 1958 , that I last saw the deceased alive on March 13, 1958 , and that death occurred at 11:53PM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Deer's Head State Hospital		DATE SIGNED 3/14/58	
ACTUAL SIGNATURE <i>V. Juerman</i>		M.D.							
PHYSICIAN'S NAME (Type) V. Juerman, M. D.						Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 16, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Petersburg Cemetery		22d. LOCATION (City, town, or county) Near Hurlock, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		ADDRESS J. J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE Mar 14 1958		24b. REGISTRAR'S SIGNATURE <i>John J. Frampton</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

MAR 15 1950

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3927

CERTIFICATE OF DEATH

03916

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
WICOMICO				a. STATE	Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY	Wicomico
SALISBURY		2 days.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Salisbury (See birth certificate)		d. STREET ADDRESS	622 Westover Circle
Peninsula General Hospital.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year
DONALD	Leon	JACKSON	.	MARCH	16, 1958
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR Months Days Hours Min.
MALE	Colored	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	MARCH 14, 1958		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
RUDOLPH Valentine JACKSON		June ELIZABETH DALE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
(If yes, give war or dates of service)				June Elizabeth Dale, westover circle	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Prematurity		2 days	
771a X		DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)			
{		DUE TO			
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. st. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19				19	
21. I certify that I attended the deceased from March 14, 1958, to March 16, 1958, that I last saw the deceased alive on 19, and that death occurred at 11 AM, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE		M.D.		334 Camden Ave, Salisbury, MD 27801 3/16/58	
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM	
BURIAL 3/20/68				22d. LOCATION (City, town, or county) SALISBURY MD (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR MAR 24 1958	
Clinton St. Stewart, Salisbury MD				24b. REGISTRAR'S SIGNATURE C. L. Lewis	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUNAU V. S.

NO. 114 123

MEDEVAC

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Baby Boy H.I. 3928

03917

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>	c. LENGTH OF STAY IN 1b <i>2 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i> (See birth certificate)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>	e. STREET ADDRESS <i>622 Westover Circle</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Rosal. A. Jackson</i>	First <i>Rosal.</i>	Middle <i>A.</i>	Last <i>Jackson</i>		
4. DATE OF DEATH <i>March 16, 1958</i>	Month <i>March</i>	Day <i>16</i>	Year <i>1958</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 14, 1958</i>		
9. AGE (In years last birthday) yr. <i>1</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>	11. KIND OF BUSINESS OR INDUSTRY <i>None</i>	12. BIRTHPLACE (State or foreign country) <i>None</i>		
13. CITIZEN OF WHAT COUNTRY? <i>None</i>	14. MOTHER'S MAIDEN NAME <i>Jane Elizabeth Dale</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Jane Elizabeth Dale, Westover Circle</i>	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Residuality</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. <i>March 16, 1958</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>March 14, 1958</i> , to <i>March 16, 1958</i> , that I last saw the deceased alive on <i>March 16, 1958</i> , and that death occurred at <i>9 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>334 Cambridge Salisbury Md.</i> DATE SIGNED <i>3/16/58</i>					
ACTUAL SIGNATURE <i>William B. Gray</i>	PHYSICIAN'S NAME (Type) <i>William B. Gray</i>	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>3/20/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Houston</i>	22d. LOCATION (City, town, or county) (State) <i>Salisbury Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clinton Stewart</i>	ADDRESS <i>Salisbury Md.</i>	24a. REC'D BY REGISTRAR DATE <i>MAR 24 '58</i>	24b. REGISTRAR'S SIGNATURE <i>W. E. Smith</i>		

PIPERAUX V. S.

MAR 24 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

See: Birth Cert.

03918

3929

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Wicomico</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. LENGTH OF STAY IN 1b <i>RURAL</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mardella</i>		d. STREET ADDRESS <i>Route # 2</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <i>Jones</i>	Middle <i></i>	Last <i>Jones</i>	4. DATE OF DEATH <i>MARCH 24,</i>	Month <i>MARCH</i>	Day <i>24</i>	Year <i>1958</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>MARCH 21, 1958</i>	9. AGE (In years lost birthday) yrs <i></i>	IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS Days <i></i>	Hours <i></i>	Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Salisbury, Maryland</i>		12 CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>Lewis Jones</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Jones</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Lewis Jones, Mardella Md.</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>756.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		<i>Aspiration pneumonia</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 Days.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Multiple Congenital anomalies</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i></i>		(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <i>7:23 A.M.</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Alfred C. Kolls</i> ADDRESS (Street, city or town, state) <i>M.D. Medical Center</i> DATE, SIGNED <i>3/27/58</i>									
PHYSICIAN'S NAME (Type)		<i>Salisbury Maryland</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>3/27/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Church Cemetery</i>		22d. LOCATION (City, town, or county) <i>Mardella</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clinton F. Stewart</i>		ADDRESS <i>916</i>		24a. REC'D BY REGISTRAR <i>DATE 28 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Q. J. - euen</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 9 1933

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

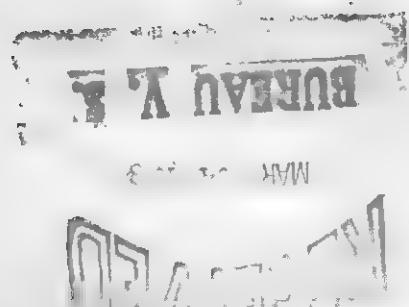
Reg. Dist. No.

03919

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		3930 MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chance</i> d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Mary</i>		First <i>Fernande</i>	Middle <i>Col.</i>	Last <i>Jones</i>	4. DATE OF DEATH <i>April 17 1891</i> Month <i>March</i> Day <i>19</i> Year <i>1958</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>April 17 1891</i>	9. AGE (In years last birthday) <i>66 yrs.</i> IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Traves Wilson</i>		14. MOTHER'S MAIDEN NAME <i>Lucy Wilson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Samuel Jones, Chance, Md.</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Insufficiency</i>				INTERVAL BETWEEN ONSET AND DEATH	
1445A Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Hypertensive Heart Disease					
(c)					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 17, 1958, to Mar. 19, 1958, that I last saw the deceased alive on Mar. 19, 1958, and that death occurred at 12 2/3 AM, from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Samuel Jones</i>		M.D.		ADDRESS (Street, city or town, state) <i>Salisbury, Md.</i> DATE SIGNED <i>Mar 21, 1958</i>	
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>LAWRENCE</i>		22b. DATE THEREOF <i>3/23/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>House Jacob</i>	
22d. LOCATION (City, town, or county) <i>Charles</i>				(State) <i>MARYLAND</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wellman H. Jones, Jr., Funeral Director</i>		ADDRESS <i>Wellman H. Jones, Jr., Funeral Director</i>		24a. REC'D BY REGISTRAR <i>Mar 24 58</i>	
				24b. REGISTRAR'S SIGNATURE <i>Curvesuch</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3978 CERTIFICATE OF DEATH

03320

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] o. STATE Maryland		b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tyaskin		c. LENGTH OF STAY IN lb Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tyaskin		d. STREET ADDRESS /		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RICHARD				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First RICHARD	Middle E.	Last LARMORE	4. DATE OF DEATH March 22	Month March	Day 22	Year 1958
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9/8/74	9. AGE (In years lost birthday) 83 yrs.	IF UNDER 1 YEAR 6	IF UNDER 24 HRS. 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States		
13. FATHER'S NAME George H. Larmore				14. MOTHER'S MAIDEN NAME Mary H. Hemmons		Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Mrs Russell Heath, Nanticoke, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		Cerebral Hemorrhage: 48 hours Generalized Arteriosclerosis 10 years						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 29 March 1948 to 22 March 1958 , that I last saw the deceased alive on 22 March 1958 , and that death occurred at 6 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Nanticoke Md. DATE SIGNED 3/24/58						
ACTUAL SIGNATURE Richard H. Saunders M.D.								
PHYSICIAN'S NAME (Type) Richard H. Saunders		Nanticoke, Maryland 3/24/58						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/25/58	22c. NAME OF CEMETERY OR CREMATORIUM Tyaskin Cem.		22d. LOCATION (City, town, or county) Tyaskin, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles D. Merle		ADDRESS Bivalve, Maryland		24a. REC'D BY REGISTRAR APR 8 '58		24b. REGISTRAR'S SIGNATURE Alfred		

ATTENTION STAFF: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2
RECEIVED

APR 8 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3931

CERTIFICATE OF DEATH

03921

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>SOMERSET</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. LENGTH OF STAY IN 1b <i>18 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Upper Fairmount</i>		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>Annie</i>	Middle <i>M.</i>	Last <i>Lattimore</i>	4. DATE OF DEATH <i>MARCH 28, 1958.</i>	Month <i>MARCH</i>	Day <i>28</i>	Year <i>1958</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>July 6, 1873</i>	9. AGE (in years less birthday) <i>84</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Jane Townsend</i>		14. MOTHER'S MAIDEN NAME <i>Adella Cullen</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>80-1-1221</i>		17. INFORMANT <i>Dr. E.W. Lattimore, Fairmount</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic C.V.D.</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>FRACTURE Comm. Rt. hip.</i>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. st. p. m. <i>19</i>		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>UPPER FAIRMOUNT SOMERSET Md.</i>		(County) (State)	
21. I certify that I attended the deceased from <i>MARCH 11, 1958</i> , to <i>MARCH 28, 1958</i> , that I last saw the deceased alive on <i>MARCH 28, 1958</i> , and that death occurred at <i>10 A.M.</i> from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>William B. Long</i>		ADDRESS (Street, city or town, state) <i>Medical Center Building 3d 3/28/58</i>							
PHYSICIAN'S NAME (Type)		DATE SIGNED <i>3/28/58</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 3-30-58</i>		22b. DATE THEREOF <i>3-30-58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Bryn Mawr Cemetery</i>		22d. LOCATION (City, town, or county) <i>Craigfield, MD</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Levin Wilson Prineus Arms</i>		ADDRESS <i>1000 W. Pratt Street</i>		24a. REC'D BY REGISTRAR <i>REG'D 3/30/58</i>		24b. REGISTRAR'S SIGNATURE <i>John couch</i>			

BUREAU Y A E

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3932

CERTIFICATE OF DEATH

03922

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u>		b. COUNTY <u>Sussex</u>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Selbyville</u>		d. STREET ADDRESS <u>RFD</u>								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>RFD</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <u>Flossie</u>		First	Middle	Last	4. DATE OF DEATH <u>Lekites</u>	Month	Day	Year						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 25, 1899</u>	9. AGE (In years (month/day) yrs.) <u>33</u>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>								
13. FATHER'S NAME <u>DANIEL MURRAY</u>		14. MOTHER'S MAIDEN NAME <u>LUCY DAISEY</u>												
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Jay Lekites</u>		Address <u>Selbyville, Del.</u>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>904.9</u> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <u>Bilateral pneumonia</u> DUE TO (c) <u>Fracture of femur</u> DUE TO (d) <u>2 months</u> INTERVAL BETWEEN ONSET AND DEATH <u>61/2 weeks</u>														
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)														
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white <input checked="" type="checkbox"/> p. m. <u></u> at work <input type="checkbox"/>							20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>JAN 26, 1958</u>		(County) <u>MARCH 4, 1958</u>	(State) <u></u>
21. I certify that I attended the deceased from <u>JAN 26, 1958</u> , to <u>MARCH 4, 1958</u> , that I last saw the deceased alive on <u>3/4, 1958</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.									ADDRESS (Street, city or town, state)		DATE SIGNED			
ACTUAL SIGNATURE <u>Willie H. Fisher, Jr.</u>									M.D.					
PHYSICIAN'S NAME (Type)														
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremated</u>		22b. DATE THEREOF <u>3/7/58</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>NGO</u>		22d. LOCATION (City, town, or county) <u>Goshen, Del.</u>		(State)						
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willie Whaley Selbyville, Del.</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>Mar 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>John Lewis</u>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

MAR 6 1959

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FILED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3933

CERTIFICATE OF DEATH

Reg. Dist. No. 13923

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		b. COUNTY Wicomico	
c. LENGTH OF STAY IN 1b RURAL and give nearest town Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS 220 E. Church St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First SARAH	Middle ELIZABETH	Last LEWIS
4. DATE OF DEATH	Month MARCH		Day 9th
	Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 24, 1882
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months 2	11. IF UNDER 24 HRS. Hours 15 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Pittsville, Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME James Edward Moore		14. MOTHER'S MAIDEN NAME Theodosia Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Lewis E. Williams (Daughter) Address St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Persecutoma adeno - Intestinal Tract. 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-1</u> , 19 <u>57</u> , to <u>3-9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-9</u> , 19 <u>58</u> , and that death occurred at <u>3:00 P.M.</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. <u>Dr. William Smith</u> DATE SIGNED <u>Med. Center St. Mar. 10/58</u>	
ACTUAL TIME		PHYSICIAN'S NAME (Type) Dr. William Smith	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Mar. 11, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Lewis Family Cem.	
22d. LOCATION (City, town, or county) Willards, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND		24a. REC'D BY REGISTRAR MAR 14 '58	
		24b. REGISTRAR'S SIGNATURE <u>Mr. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAR 14 1960

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03924

3934

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 6 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Jesse		First	Middle	Losl	4. DATE OF DEATH Lidden	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9/15/1880	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ? Jnk		10b. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas Lidden		14. MOTHER'S MAIDEN NAME Sally Cranner							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Jnk		16. SOCIAL SECURITY NO		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5/10A		Intestinal hemorrhage, massive				INTERVAL BETWEEN ONSET AND DEATH 9 hours			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Cause - unknown							
DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic heart disease; pulmonary emphysema; healed duodenal ulcer									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) ulcer		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 30, 1957, to March 31, 1958, that I last saw the deceased alive on March 31, 1958, and that death occurred at 9:15 AM, from the causes and on the date stated above.								ADDRESS (Street, city or town, state)	DATE SIGNED 3/31/58
ACTUAL SIGNATURE G. Kosmahl		M.D. Deer's Head State Hospital		Physician's NAME (Type) G. Kosmahl, M. D.		Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/3/58		22c. NAME OF CEMETERY OR CREMATORIUM Washington Cemt. Hurlock		22d. LOCATION (City, town, or county) Md		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE S. deCompte		ADDRESS Commodity Rd		24a. REC'D BY REGISTRAR DATE APR 2 '58		24b. REGISTRAR'S SIGNATURE G. Kosmahl			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

APR 2 1958

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3935

CERTIFICATE OF DEATH

03925

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City	
3. NAME OF DECEASED (Type or print) First Beni Middle Mazcko		4. DATE OF DEATH Month March Day 15 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/21/1881
9. AGE (In years lost birthday) 76 yrs		10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 40 U. I. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under: lying cause lost. (b) _____ DUE TO (c) _____		Anterior myocardial infarction INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral thrombosis with right hemiplegia and motor aphasia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19 Day	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 10, 1958, to March 15, 1958, that I last saw the deceased alive on March 15, 1958, and that death occurred at 9:45A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Gehard Kosmahl</i>		ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 3/15/58	
PHYSICIAN'S NAME (Type) Gehard Kosmahl, M. D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 17/58	
22c. NAME OF CEMETERY OR CREMATORIUM Basic Cem.		22d. LOCATION (City, town, or county) Burial Barclay Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellow		ADDRESS Wilmington Md.	
24a. REC'D BY REGISTRAR DATE MAR 19 '58		24b. REGISTRAR'S SIGNATURE A. Kosmahl	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MAR 19 1958

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2 File No. 3-11-58

Reg. Dist. No. 13926

3936 CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Wicomico		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) / Middleburg Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		e. STREET ADDRESS Maple Shade Nursing Home 519 Priscilla Street 101 Bldg., Sharptown Road	
f. DATE OF DEATH McMURRAY		g. STREET ADDRESS Maple Shade Nursing Home 519 Priscilla Street 101 Bldg., Sharptown Road	
h. AGE (In years last birthday) 76 yrs		i. IF UNDER 1 YEAR IF UNDER 24 HRS 10 Months 6 Days Hours Min	
j. SEX Female		k. COLOR OR RACE White	
l. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		m. DATE OF BIRTH April 26, 1881	
n. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		o. BIRTHPLACE (State or foreign country) South Dakota	
p. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work		q. KIND OF BUSINESS OR INDUSTRY None	
r. FATHER'S NAME Unk		s. MOTHER'S MAIDEN NAME Unk	
t. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no; unknown) No		u. SOCIAL SECURITY NO.	
v. INFORMANT Rev. Posey A. Shupe (Minister) 519 Priscilla Street, Salisbury, Maryland		w. CITIZEN OF WHAT COUNTRY? U.S.A.	
x. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 445X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO DUE TO (c)		y. INTERVAL BETWEEN ONSET AND DEATH 3 hrs. Hypertensive Heart Disease	
z. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		aa. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
bb. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		cc. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
dd. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		ee. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
ff. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		gg. (City or town) (County) (State)	
hh. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.		ii. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE David Gilmane M.D. Salisbury, Md. Mar. 4, 1958	
jj. PHYSICIAN'S NAME (Type) David Gilmane Medical Center-Salisbury Md 3-4-58		kk. BURIAL, CREMATION, REMOVAL (Specify) Burial Mar. 5, 1958	
ll. DATE THEREOF Mar. 5, 1958		mm. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park	
nn. LOCATION (City, town, or county) Salisbury, Maryland		oo. LOCATION (City, town, or county) (State)	
pp. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND		qq. REC'D BY REGISTRAR DATE MAR 6 58	
rr. REGISTRAR'S SIGNATURE R. J. Holloway		ss. REGISTRAR'S SIGNATURE R. J. Holloway	

BUREAU V. S.

MAR 6 1958

KIEGEVIEU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3937

CERTIFICATE OF DEATH

03927

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) o STATE Maryland b COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 307 Penn St		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
3. NAME OF DECEASED (Type or print) BLANCHE		Middle EDITH	Last MILLS
4. DATE OF DEATH MARCH 25th 1958	Month Day Year	5. SEX Female	6. COLOR OR RACE White
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 4, 1887	
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Quantico, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Marcellus Windsor Bailey		14. MOTHER'S MAIDEN NAME Annie Elizabeth Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO (c) Arteriosclerotic Cardiovascular Disease 3 yrs +		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9/23, 1927, to 3/25, 1958, that I last saw the deceased alive on 3/14, 1958, and that death occurred at 10A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Rufus Gardner Jr.		ADDRESS (Street, city or town, state) M.D. Peachbluff Rd	
PHYSICIAN'S NAME (Type) Dr. Rufus Gardner Jr.		DATE SIGNED 3/26/58	
22a. BURIAL, CREMATON, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 28, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery		22d. LOCATION (City, town, or county) Salisbury, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND		ADDRESS	
		24a. REC'D BY REGISTRAR DATE MAR 28 '58	24b. REGISTRAR'S SIGNATURE W. reich

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file in the funeral director's office. Please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LEAU M.

3 1958

LEAU M.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or in my designated agent, prior to burial, cremation, or removal, and is any expense within 72 hours after death.

VS A15ME
BM 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13928

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND	2. USUAL RESIDENCE (Where deceased lived) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	c. LENGTH OF STAY (in 1b) /				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen. Gen. Hospital	e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				
f. STREET ADDRESS 310 Naylor St	g. IS PE IDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) WALTER HERMAN MITCHELL	First Middle Last	4. DATE OF DEATH MARCH 31 st 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1889	9. AGE (in years for birthday) 69 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Painter	10b. KIND OF BUSINESS OR INDUSTRY Painting	11. BIRTHPLACE (State or foreign country) Delmar, Delaware	12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Burkett Mitchell	14. MOTHER'S MAIDEN NAME Mary Hastings				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Flossie C. Mitchell (Wife) Address St. Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Broncho-pneumonia				INTERVAL BETWEEN ONSET AND DEATH hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Fractured right femur				7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fractured right femur.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell out of bed.				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 3-26-58	20d. INJURY OCCURRED Where at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Salisbury	(County) Wicomico	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Dr. Earl L. Royer</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED March 31 1958
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 3, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery	22d. LOCATION (City, town, or county) Salisbury, Maryland	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY	SALISBURY MARYLAND	24a. REC'D BY REGISTRAR APR 2 '58	24b. REGISTRAR'S SIGNATURE <i>John F. Rich</i>		

RECEIVED
BUREAU V.

APR 2 1958

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. After this copy has been executed by the attending physician or hospital, the third copy of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

Vs AUSC 1-55 10-11

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 43 & 49 - Film 0227 - 4/10/58-mb

03921

CERTIFICATE OF DEATH

3939

Reg. Dist. No. . . .

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	MARYLAND LENGTH OF STAY (In this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY SALISBURY MD. (If rural give location)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS	J.B. Hospital	STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)	(First) Cora (Middle) C. (Last) Moore	4. DATE (Month) (Day) (Year) OF DEATH 3 24 1958			
5. SEX female	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) married	8. DATE OF BIRTH Jan. 16, 1902	9. AGE last birthday 56 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Merchant	11. BIRTHPLACE (State or foreign country) Chambers md	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Geo Wright		14. MOTHER'S MAIDEN NAME Hattie Biene			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk) No		16. SOCIAL SECURITY NO. ?	17. INFORMANT & ADDRESS Moore		
18. MEDICAL CERTIFICATION					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Cerebral Hemorrhage			
IMMEDIATE CAUSE 2-18		(A) DUE TO		Cerebral Atherosclerosis	
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Essential Hypertension					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. et work		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from..... 3/20, 1958, to..... 3/27, 1958, that I last saw the deceased alive on..... 3/27, 1958, and that death occurred at..... M, from the causes and on the date stated above. SIGNATURE Daniel DeLoach M.D. ADDRESS Salisbury Md DATE SIGNED Apr. 31, 1958					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4-3-58	NAME OF CEMETERY OR CREMATORIAL Mt Calvary Cem.	LOCATION (City, town, or county) F. S. Hospital Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE C. DeLoach	25. FUNERAL DIRECTOR'S SIGNATURE Beauchamp Elmer		ADDRESS
DATE APR 7 '58					

1945

1945

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03930

3940

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Riverside Nursing Home		d. STREET ADDRESS 1004 Camden Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ERNEST INGERSOLL		First	Middle	Last	4. DATE OF DEATH NOCK	Month MARCH	Day 21st	Year 19 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Dec. 5, 1879	9. AGE (In years from birthday) 78 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Shoe Salesman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mappsville, Virginia		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Nehemiah Wallop Nock		14. MOTHER'S MAIDEN NAME Emily Byrd						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Ernest J. Nock (Son) 1004 th Camden Ave. Salisbury, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) DUE TO CONGESTIVE HEART FAILURE. 1 day ATHROSCLEROTIC CEREBRO CARDIO VASCULAR Year		
						INTERVAL BETWEEN ONSET AND DEATH 5 days		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION PARKINSONS DISEASE						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 1:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE				M.D.				
PHYSICIAN'S NAME (Type) Dr. O.J. Burton		Maryland Ave. Salisbury, Maryland Mar. 22/58						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 24, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Wicomico Memorial Park		22d. LOCATION (City, town, or county) Salisbury, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND		ADDRESS		24a. REC'D. BY REGISTRAR MAR 26 '58		24b. REG STAR'S SIGNATURE W. E. Deane		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 1928

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03931

3941

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanticoke		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First SAMUEL	Middle 	Last NUTTER	4. DATE OF DEATH March 7 1958	Month March	Day 7	Year 1958
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/4/75	9. AGE (In years lost birthday) 82 yrs	IF UNDER 1 YEAR? IF UNDER 24 HRS. Months 8 Days 23 Hours 0 Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Oyster Longer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Martin Nutter, Nanticoke, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO <i>Gastric Perforation</i> INTERVAL BETWEEN ONSET AND DEATH 1 year . Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Intestinal Obstruction</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/13 1955 to 3/7 1958 that I last saw the deceased alive on 3/7 1958 , and that death occurred at 5:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Richard H. Saunders</i>		ADDRESS (Street, city or town, state) Nanticoke, Md.		DATE SIGNED 3/7/58			
PHYSICIAN'S NAME (Type) Richard H. Saunders							
22a. BURIAL, CREMATION, REMOVAL (Specify) 3/10/58 Burial		22b. DATE THEREOF Burial		22c. NAME OF CEMETERY OR CREMATORIUM Nanticoke Cem.		22d. LOCATION (City, town, or county) Nanticoke, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. H. Jesuit, Bivalve, Maryland</i>		ADDRESS Bivalve, Maryland		24a. REC'D BY REGISTRAR DATE MAR 17 '58		24b. REGISTRAR'S SIGNATURE <i>A. E. Saunders</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

MAR 17 1958

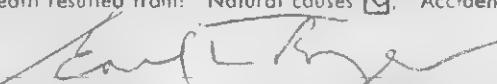
REGELEAU

13932

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and return them within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 16 X	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen. Gen. Hospital		e. STREET ADDRESS Parsonage St	
3. NAME OF DECEASED (Type or print) MILDRED ROSALIE OWENS		4. DATE OF DEATH MARCH 27 th 1958	
5. SEX Female White WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Dec. 30, 1921	
10a. USUAL OCCUPATION (Give kind of work done) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Allen, Maryland	
13. FATHER'S NAME Walter William Bounds		14. MOTHER'S MAIDEN NAME Rosa M. Malone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Catherine Willey (Sister) Main St. Fruitland, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 400-1 DUE TO myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO coronary occlusion (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		24 hours	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) Dr. Earl L. Royer		DATE SIGNED March 29 1958	
22e. BURIAL CREMATION, 22f. DATE THEREOF REMOVAL (Specify) Burial Mar. 30, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Allen Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		22d. LOCATION (City, town, or county) Allen, Maryland	
		24a. REC'D BY REGISTRAR MAR 31 '58	
		24b. REGISTRAR'S SIGNATURE 	

BUREAU Y.

MR 31 1958

RECEIVED

1

**FOR STATE
HEALTH DEPT.**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3979 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13933

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

REPUTY [REDACTED] EXAMINER This cert. if filed, should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsburg		c. LENGTH OF STAY IN Tb Parsonsburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or print) Baby Boy		First Parker	Middle Parker
4. DATE OF DEATH 3 20 58		Month 3	Day 21
5. SEX M		6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH 3-20-58		9. AGE (In years last birthday) yrs. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Monroe Parker		14. MOTHER'S MAIDEN NAME Dorothy Edwards	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO None	
17. INFORMANT Monroe Parker, Parsonsburg, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 7620 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause first. (c)		INTERVAL BETWEEN ONSET AND DEATH 10 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Earl L. Royer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Earl L. Royer</i>		DATE SIGNED 3-21-58	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 3/22/1958	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Calvary Cemetery		22d. LOCATION (City, town, or county) Fruitland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. F. Stewart Funeral Home, Salisbury, Md.</i>		24a. REC'D BY REGISTRAR DATE MAR 28 '58	
		24b. REG STRGR'S SIGNATURE <i>Earl L. Royer</i>	

LIBRARY
MAR 23 1968

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03934

3943

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] Salisbury		c. LENGTH OF STAY IN lb Pen. Gen. Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico			
						c. CITY OR TOWN [If outls de corporate limits, write RURAL and g ve nearest town] Parsonsburg					
						d. STREET ADDRESS P.O.B.# 6		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First JAMES	Middle FRANK	Last PARKER	4. DATE OF DEATH March 31st 1958	Month Year					
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 27, 1937		9. AGE [In years last birthday] 20 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee of Clothing Factory		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A					
13. FATHER'S NAME James Albert Parker		14. MOTHER'S MAIDEN NAME Ruth E. Walker									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO. [If yes, g ve war or date of serv]		17. INFORMANT Mr. James Albert Parker (Father) P.O.B# 6 Parsonsburg, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Hemorrhage due to ruptured spleen, liver and bladder. 7 hours INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Thrown from car when car ran off road.											
20c. TIME OF INJURY Hour 5:30 p.m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) R F D # 50		20f. (City or town) Parsonburg		(County) Wicomico		(State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <i>Earl L. Royer</i>		EXAMINER'S NAME (Type) Dr. Earl L. Royer		MD CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED March 31 1958					
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 3, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Parsonsburg Cemetery		22d. LOCATION (City, town, or county) Parsonsburg, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR APR 2 '58		24b. REGISTRAR'S SIGNATURE <i>Ashe</i>					
VS. A15ME SM 2/57											

PRIMAVERA

1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3944

CERTIFICATE OF DEATH

03935

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Allegany</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Allegany</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sabrewood</i>		c. LENGTH OF STAY IN lb <i>1</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sabrewood</i>		d. STREET ADDRESS <i>1 87301</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Private General Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Julia</i>	Middle <i>A.</i>	Last <i>Parker</i>	4. DATE OF DEATH <i>March 24</i>	Month <i>March</i>	Day <i>24</i>	Year <i>1958</i>
\$ SEX <i>Female</i>	6. COLOR OR RACE <i>Blond</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>3-21-58</i>	9. AGE (in years last birthday) yrs. <i>8</i>	10. IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>2</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>now</i>		11. BIRTHPLACE (State or foreign country) <i>Sabrewood Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>William Parker</i>		14. MOTHER'S MAIDEN NAME <i>Vergenia Waters</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>William Parker</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac decompensation</i>						INTERVAL BETWEEN ONSET AND DEATH	
DUE TO <i>7/4/1</i>		(b) <i>Congenital Heart Disease</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(c) <i>Atresia of right ventricle</i> <i>absence of proximal pulmonary artery</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month <i>March</i>	Day <i>21</i>	Year <i>1958</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Medical Center Sabrewood</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>March 21, 1958</i> , to <i>March 24, 1958</i> that I last saw the deceased alive on <i>March 24, 1958</i> , and that death occurred at <i>12:20 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Medical Center Sabrewood</i> DATE SIGNED <i>3/25/58</i>							
ACTUAL SIGNATURE <i>William C. Morgan</i>		M.D.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-28-58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt Calvary Cem. Franklin Md</i>		22d. LOCATION (City, town or county) (State) <i>Franklin Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Beauregarde</i>		ADDRESS <i>97 West</i>		24a. REC'D BY REGISTRAR <i>D. [Signature]</i>		24b. REGISTRAR'S SIGNATURE <i>D. [Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Funeral director, To Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

BUREAU V.

DR 2 1958

KIEGEVÉD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3945

CERTIFICATE OF DEATH

03936

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsburg				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital	d. STREET ADDRESS In Village		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First EDWIN	Middle EVERETTE	Last PARSONS	4. DATE OF DEATH MARCH 1st 19 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 21, 1915	9. AGE (In years (last birthday) 42 yrs.)	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee (A. W. Perdue & Son) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A
13. FATHER'S NAME Herman M. Parsons		14. MOTHER'S MAIDEN NAME Irene Virginia Taylor				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) Yes		16. SOCIAL SECURITY NO. W. W. # II		17. INFORMANT Mrs. Margaret Evans (Sister) R.D. # 2 Pittsville, Maryland		Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 002 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) DUE TO (c)		Emphysema - Gabezia - Pulmonary Tuberculosis & Bronchitis Pulmonary fistula		INTERVAL BETWEEN ONSET AND DEATH 2 weeks Probably years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/14, 1958, to 3/1, 1958, that I last saw the deceased alive on 3/1, 1958, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state)						DATE SIGNED 3/3/58.
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Dr. Andrew Mitchell Dr. O.J. Burton		M.D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 4, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Melsons Cemetery		22d. LOCATION (City, town, or county) R.D. # Delmar, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND		ADDRESS HOLLOWAY & COMPANY - SALISBURY MARYLAND		24a. REC'D BY REGISTRAR MAR 5 '58 DATE		24b. REGISTRAR'S SIGNATURE John E. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

MAR 5 1958

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03937

3946

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>PENINSULA GENERAL Hosp.</i>		d. STREET ADDRESS <i>401 Naylor Street</i>	
3. NAME OF DECEASED (Type or print) <i>GEORGE Mony-Joe</i>		First <i>Passen</i>	Middle <i></i>
3. NAME OF DECEASED (Type or print) <i>GEORGE Mony-Joe</i>		Last <i>Passen</i>	4. DATE OF DEATH <i>3/9</i>
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>5 March 1958</i>		9. AGE (In years lost birthday) yrs. <i>3</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>	
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
13. FATHER'S NAME <i>GEORGE E. Passen</i>		14. MOTHER'S MAIDEN NAME <i>Rena F. Wilson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>— — —</i>	
17. INFORMANT <i>George E. Passen</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intra cranial defect, congenital, type undeter- mined</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <i>Frematurity</i>	
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		INTERVAL BETWEEN ONSET AND DEATH <i>4 d.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3-5</i> , 19 <i>58</i> , to <i>3-9</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>3-8</i> , 19 <i>58</i> , and that death occurred at <i>3:05 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert E. Herndon</i> ADDRESS (Street, city or town, state) <i>702 Camden Ave., Salisbury, Md.</i> DATE SIGNED <i>3-9-58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-9-1958</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>JARSONS CEMETERY</i>		22d. LOCATION (City, town, or county) <i>Salisbury, Md.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Thomas J. Wallace, Salisbury, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 10 1958</i>	
		24b. REGISTRAR'S SIGNATURE <i>Paul L. S.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAR 10 1928
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03938

CERTIFICATE OF DEATH

Reg. Dist. No.

3947

1. PLACE OF DEATH

a. COUNTY

Wicomico

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN lb

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)

a. STATE

VIRGINIA

b. COUNTY

ACCOMACK

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

HORNTOWN

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?

YES NO 3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

19

1958

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

9. AGE (In years last birthday)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which

gave rise to immediate

cause (a), stating the under-

lying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN

ONSET AND DEATH

4 years

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year

Hour a. m.

p. m.

19

at work at work

20d. INJURY OCCURRED

White Nat white at work at work

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from

3-15, 1958, to

3-17, 1958, that I last saw the deceased

alive on 3-19, 1958, and that death occurred at 5 P.M.

from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

MAR 24 '58

DATE

24b. REGISTRAR'S SIGNATURE

W. A. Shields

New Church, Va.

W. A. Shields

New Church, Va.

BUREAU Y

MAR 24 1958



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3948

Items 8, 9, Film # 227 b, 3/58 GG
CERTIFICATE OF DEATH

Reg. Dist. No.

03939

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Salisbury		c. LENGTH OF STAY IN 1b 40 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 301 N. Division St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 301 N. Division St.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First ANNIE	Middle TOADVINE	Last PERDUE	4. DATE OF DEATH 1871	Month 3	Day 24	Year 1958
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Mar. 20, 1871	9. AGE (In years at birthday) 89 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Stephen P. Toadvine				14. MOTHER'S MAIDEN NAME Martha Ruark				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. H.H. Hanna Jr., Salisbury, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Anterior atherosclerotic heart disease (c)				Myocardial Insufficiency Anterior atherosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 5 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Parsons Cemetery		20f. (City or town) Salisbury		(County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Dr. David J. Gilmore M.D. Salisbury, Maryland								DATE SIGNED 3/25/58
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/27/58		22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery		22d. LOCATION (City, town, or county) Salisbury, Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland		ADDRESS Nemoy & Bell		24a. REC'D BY REGISTRAR MAR 28 '58		24b. REGISTRAR'S SIGNATURE Albert E. Schuck		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be held until the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 28 1958

PEGGY FEU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03940

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 205 West Locust St		d. STREET ADDRESS 205 West Locust St	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HILDA	First MIDDLE ANN	Last PERRY	4. DATE OF DEATH MARCH 10 th 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1884	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years lost birthday) 73 yrs. IF UNDER 1 YEAR Months 11 Days 15 Hours Min	
13. FATHER'S NAME Michael Donovan		14. MOTHER'S MAIDEN NAME Julia Griffith	12. CITIZEN OF WHAT COUNTRY? U S A	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. <input type="checkbox"/> INFORMANT Mr. John M. Perry (Husband) 205 W. Locust St. Salisbury, Md.	17. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral arteriosclerosis</i> DUE TO (c) <i>Hypertension & V. D. Disease</i> INTERVAL BETWEEN ONSET AND DEATH 2 wks ?	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 374 Camden Ave. Salisbury	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 1957, to March 11, 1958, that I last saw the deceased alive on _____, 1958, and that death occurred at 9:00 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>William Gray</i> ADDRESS (Street, city or town, state) Dr. William Gray M.D. 374 Camden Ave. Salisbury, Md. Mar. 13 1958 DATE SIGNED 3/13/58				
22a. BURIAL, CREMATION, REMOVED <input type="checkbox"/> <input checked="" type="checkbox"/> Mar. 13, 1958		22b. DATE THEREOF Mar. 13, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery	22d. LOCATION (City, State, County) Washington 20001 Southeast D.C.
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND		ADDRESS HOLLOWAY & COMPANY - SALISBURY MARYLAND	24a. REC'D BY REGISTRAR DATE MAR 14 '58	24b. REGISTRAR'S SIGNATURE <i>John L. Smith</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

MAR 14 1966

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3950

CERTIFICATE OF DEATH

Reg. Dist. No.

03941

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) a. STATE MARYLAND		If institution: Residence before admission b. COUNTY WORCESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		e. STREET ADDRESS RFD. # 3		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Clarence E. Pettit		First	Middle	Last	4. DATE OF DEATH March	Month	Day	Year	9 1958
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH July 25, 1885	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME GEORGE PETTIT		14. MOTHER'S MAIDEN NAME NANCY POWELL							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO.		16. SOCIAL SECURITY NO 213-22-8791		17. INFORMANT MRS. GUSSIE R. PETTIT, Pocomoke City, MD.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia						INTERVAL BETWEEN ONSET AND DEATH 12 hours			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. b) DUE TO c)									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Pocomoke City		(County)	(State)
21. I certify that I attended the deceased from 3-5 , 19 58 , to 3-9 , 19 58 , that I last saw the deceased alive on 3-9 , 19 58 , and that death occurred at 7:55 AM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Salisbury, Md.		DATE SIGNED 3-9-58	
ACTUAL SIGNATURE Willie B. Elliott		M.D.							
PHYSICIAN'S NAME (Type) John S. Watson									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-11-58		22c. NAME OF CEMETERY OR CREMATORIUM BAPTIST CEMETERY		22d. LOCATION (City, town, or county) Pocomoke City, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Watson		ADDRESS Pocomoke, MD.		24a. REC'D BY REGISTRAR DATE MAR 12 '58		24b. REGISTRAR'S SIGNATURE John S. Watson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGELVÉD
BUREAU N.Y.

MAR 12 1963

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3951 CERTIFICATE OF DEATH

Reg. Dist. No.

03942

1. PLACE OF DEATH a. COUNTY		Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Salisbury				Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		f. DATE OF DEATH		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Pen. Gen. Hospital		Ocean City Road		MARCH 28th 1958		Year 58	
3. NAME OF DECEASED (Type or print)		First BABY	Middle	Lost PHIPPIN	Month	Day	Year
4. SEX Female		5. COLOR OR RACE White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	7. DATE OF BIRTH March 28, 1958	8. AGE (in years last birthday) 0	9. IF UNDER 1 YEAR Months 0	10. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
None		None		Pen. Gen. Hosp Salisbury, Md.		U S A	
13. FATHER'S NAME Elmer Francis Phippin				14. MOTHER'S MAIDEN NAME Emily Arvey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <small>If yes, no or unknown</small>		16. SOCIAL SECURITY NO		17. INFORMANT Mr. E. Francis Phippin (Father) R.D.# 3 Ocean City Rd Salisbury, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Multiple congenital deformities</i> <small>Large pharyngeal</small> DUE TO <i>Causes affecting lungs due to presence of tumor</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Congenital absence of rt. eye</i> DUE TO <i>Clifft palate, -</i> (c) <i>-</i>							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 31 28, 1958, to 31 28, 1958, that I last saw the deceased alive on 3/28, 1958, and that death occurred at 7:50 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)							
DATE SIGNED							
ACTUAL SIGNATURE <i>E. S. Miller</i>							
PHYSICIAN'S NAME (Type)		Dr. L. V. Sohler 303 East Delmar, Maryland Mar. 31, 1958					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 31, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery		22d. LOCATION (City, town, or county) Salisbury, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR APR 2 '58		24b. REGISTRAR'S SIGNATURE <i>L. V. Sohler</i>	

BUREAU V.

APR 2 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3952

CERTIFICATE OF DEATH

Reg. Dist. No.

03943

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Wicomico</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Lewis</i>		First	Middle	Last	4. DATE OF DEATH <i>Phoebe S</i>	Month <i>March</i>	Day <i>3</i>	Year <i>1958</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 8 1893</i>	9. AGE (In years less birthday) <i>67 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>John A. Lawson</i>		14. MOTHER'S MAIDEN NAME <i>Kate Wilson</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Virginia Phoebe Salisbury</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Bilateral lobar pneumonia				INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Bleeding peptic ulcer, post. op. (c)						<i>7 days</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 2 PM, from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Willie H. Fisher</i>		M.D.		ADDRESS (Street, city or town, state)		DATE SIGNED		
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/5/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>EPISCOPAL</i>		22d. LOCATION (City, town, or county) <i>Princess Anne Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>James Dunnigan Funeral Home Inc.</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>MAR 7 1958</i>		24b. REGISTRAR'S SIGNATURE <i>W. Keenan</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 24 hours after death.

BUREAU V. S

MAR 7 1959

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3953

CERTIFICATE OF DEATH

Reg. Dist. No.

03944

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia		b. COUNTY Accomack		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Peninsula General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chincoteague		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Lillian Mae Painter		First Lillian	Middle Mae	Last Painter	4. DATE OF DEATH March 17 1958	Month March	Day 17	Year 1958
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 26 1886		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John H. Snead		14. MOTHER'S MAIDEN NAME Elizabeth B. Tester				Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Mrs. May Lyndall		INTERVAL BETWEEN ONSET AND DEATH 8 months		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypocardiac Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Heart Disease DUE TO (c) Coronary Artherosclerosis								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia Acute						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Salisbury Md		20f. (City or town) Salisbury	(County) Md	
21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____ AM, from the causes and on the date stated above. ACTUAL SIGNATURE Daniel J. Moore						ADDRESS (Street, city or town, state) Salisbury Md		
PHYSICIAN'S NAME (Type) Walter M. Black		22a. BURIAL, CREMATION, RECOLLAGE (Specify) Burial		22b. DATE THEREOF 3-19-58		22c. NAME OF CEMETERY OR CREMATORIUM Mechanics		
23. FUNERAL DIRECTOR'S SIGNATURE— Walter M. Black Chincoteague Va		ADDRESS		24a. REC'D BY REGISTRAR MAR 24 '58		24b. REGISTRAR'S SIGNATURE W. C. Clark		
				DATE				

BUREAU V. S.

MAR 24 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03945

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 7½ hours after death.

1. PLACE OF DEATH a. COUNTY		3980 Wicomico MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE Maryland b. COUNTY Wicomico		Reg. Dist. No.		
b. CITY OR TOWN [If outside corporate limts, write RURAL and give nearest town]		c. LENGTH OF STAY IN 1b Salisbury		c. CITY OR TOWN [If outside corporate limts, write RURAL and give nearest town] Salisbury		d. STREET ADDRESS Edgemont Drive (R.D.#5)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.# 2 (Near Jersey Road)				e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First HOWARD (PETE)	Middle EDWARD	Last POOLE	4. DATE OF DEATH	Month March	Day 16 th	Year 1958
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1924	9. AGE (In years at birthday) 33 yrs	10. IF UNDER 14 YRS Months 4	11. IF UNDER 24 HRS Hours 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager (Newspaper Classified Adv. \$ec)		10b. KIND OF BUSINESS OR INDUSTRY Winston-Salem N.C.		11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME George A. Poole		14. MOTHER'S MAIDEN NAME Flora Kammel						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] Yes		16. SOCIAL SECURITY NO W.W.II Navy		17. INFORMANT Mrs. Marie E. Poole (Wife) Address Drive Salisbury, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.1		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		INTERVAL BETWEEN ONSET AND DEATH Salisbury				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of Item 18.] Hole to exhaust pipe of auto.						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 3-16 p.m. 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Salisbury (County) Wicomico (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Earl Royer</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED March 17 1958		
22a. BURIAL CREMATION REMOVAL (Specify) Burial Mar 18, 1958		22b. DATE THEREOF Mar 18, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery		22d. LOCATION (City, town, or county) Salisbury, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND		ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 18 '58		24b. REGISTRAR'S SIGNATURE <i>W. P. Edwards</i>		

BUREAU Y.

MAR 14 1933

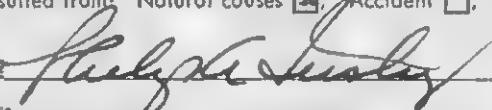
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05138

Reg. Dist. No.

3954

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Eden		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	Firm THOMAS	Middle HAMILTON	Last PUSEY, SR.	4. DATE OF DEATH Month 3 Day 23 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11/7/1877	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY Own Shop		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Zack Pusey				14. MOTHER'S MAIDEN NAME Maria Maddox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Thomas H. Pusey, Jr., Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 480.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				<i>Coronary Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Nutrol causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE 	NAME (Type) Dr. Philip A. Insley		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3-24-58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/25/58	22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery	22d. LOCATION (City, town, or county) Salisbury, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson & Co., Salisbury, Maryland			ADDRESS		24a. REC'D BY REGISTRAR DATE APR.	24b. REGISTRAR'S SIGNATURE Lil. Beards	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

V.S. A15ME(S),
5M 9/55

BUREAU V. S

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3955

CERTIFICATE OF DEATH

Reg. Dist. No.

03946

1. PLACE OF DEATH a. COUNTY <i>Albermarle</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Albermarle</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>Left</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		e. STREET ADDRESS <i>411 Cypress St</i>	
3. NAME OF DECEASED (Type or print) <i>Mary Roberts</i>		First <i>Mary</i>	Middle <i>Roberts</i>
4. DATE OF DEATH <i>3</i>		Month <i>3</i>	Day Year <i>17 1958</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		9. DATE OF BIRTH <i>Approx.</i>	10. AGE (In years last birthday) <i>88 yrs.</i>
10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Bethel Rd. Md</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
13. FATHER'S NAME <i></i>		14. MOTHER'S MAIDEN NAME <i>Rose Soutelle N.Y.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-05-3235</i>	
17. INFORMANT <i></i>		Address <i></i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Cardiovascular Disease</i> DUE TO <i>Kidney Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i> <i>One month</i>	
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____. ACTUAL SIGNATURE <i>E.A. Purcell</i>		Mr. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>652 1/2 Main St., Salisbury, Md.</i> DATE SIGNED <i></i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-23-58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Brown Acres Cem</i>		22d. LOCATION (City, town, or county) <i>Salisbury</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Booker W. Wark</i>		24a. REC'D BY REGISTRAR DATE MAR 28 '58 <i>W. L. Schaefer</i>	
ADDRESS <i></i>		24b. REGISTRAR'S SIGNATURE <i></i>	

RUEAU Y.

BAR 00 199

EDUCATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3956

CERTIFICATE OF DEATH

03947

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 23 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Dover's Dead State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dover's Dead State Hospital	
f. STREET ADDRESS ---		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First William	Middle D.	Last Roberts
4. DATE OF DEATH	Month March	Day 5th	Year 1958
S. SEX Male	6. COLOR OR RACE Yellow	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ---
9. AGE (In years last birthday) 4 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Roberts		14. MOTHER'S MAIDEN NAME Mary Roberts	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO ---	
17. INFORMANT Dover's Dead Hospital Records, Carlisle, Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 33dx DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Arteriosclerosis general DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH ---	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic cardiovascular disease.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 1, 1958</u> to <u>March 5, 1958</u> , that I last saw the deceased alive on <u>March 5, 1958</u> , and that death occurred at <u>8:25 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Dover's Dead State Hospital Salisbury, Maryland DATE SIGNED 3/5/58	
ACTUAL SIGNATURE <u>Dr. L. Fuerman</u>		PHYSICIAN'S NAME (Type) V. J. Fuerman, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Land</u>		22b. DATE THEREOF <u>3/16/58</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>J. E. Baley's Cem.</u>		22d. LOCATION (City, town, or county) <u>Desterville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Brashier, Easton, Md.</u>		24a. RECD BY REGISTRAR DATE <u>MAR 13 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Alvarez</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Y. V. SUREAU

AG - P. 1958

EDITIONS
LIVRE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3957

CERTIFICATE OF DEATH

0394X

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		c. LENGTH OF STAY IN lb 3 mo. 25 days		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY Worcester	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hosp.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Girdletree, Maryland		d. STREET ADDRESS Girdletree, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Jane	Middle Wise	Last Robinson	4. DATE OF DEATH Mar. 22	Month Mar.	Day 22	Year 19 58		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED X	8. DATE OF BIRTH Aug. 31, 1867	9. AGE (In years last birthday) 90 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0	12. IF UNDER 24 HRS. Min 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home unk		11. BIRTHPLACE (State or foreign country) unk Girdletree, Md		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Hezekeriah Jones				14. MOTHER'S MAIDEN NAME Julia Ann Mason					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO unk None		17. INFORMANT Paul J. Robinson Hospital Records		Address Girdletree, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency								INTERVAL BETWEEN ONSET AND DEATH 3 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), slotting the under- lying cause lost. (b) Arteriosclerotic cardiovascular disease								?	
DUE TO (c) Arteriosclerosis general								?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Salisbury, Maryland		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from NOV. 25, 19 57 , to Mar. 22, 19 58 , that I last saw the deceased alive on Mar. 22, 19 58 , and that death occurred at 7:15 P.M. from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) Salisbury, Maryland									
DATE SIGNED Mar. 23, 1958									
ACTUAL SIGNATURE V. Juerman		M.D.							
PHYSICIAN'S NAME (Type) V. Juerman, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 26, 58		22c. NAME OF CEMETERY OR CREMATORIUM Baptist Cemetery		22d. LOCATION (City, town, or county) Girdletree, Md			
23. FUNERAL DIRECTOR'S SIGNATURE Clay B. Dennis		ADDRESS Snow Hill, MD		24a. REC'D BY REGISTRAR MAR 26 '58		24b. REGISTRAR'S SIGNATURE Albert Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

100, 1000

LEADER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03950

Reg. Dist. No.

3958

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 8 days		2. USUAL RESIDENCE (Where deceased lived if institution; Res dence before admission) a. STATE Maryland		b. COUNTY Dorchester		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fast New Market - Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head Hospital				d. STREET ADDRESS Thompsonstown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Mary		First Rebecca		Middle Sapson		4. DATE OF DEATH March 14, 1958		Month March		Day 19	
5. SEX Female		6. COLOR OR RACE Hazel		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 15, 1975		9. AGE (In years at birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Henry Clay Young		14. MOTHER'S MAIDEN NAME Janey Mitchell									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Deer's Head Hospital Records, Salisbury, Md.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) X Cardiac insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. X Hypertensive cardiovascular renal disease						INTERVAL BETWEEN ONSET AND DEATH ?					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 21, 1958, to Mar. 4, 1958, that I last saw the deceased alive on Mar. 1, 1958, and that death occurred at 2:20 AM, from the causes and on the date stated above.										ADDRESS (Street, city or town, state)	
ACTUAL Dr. G. L. Gruenauer		M.D.								DATE SIGNED Mar. 1958	
PHYSICIAN'S NAME (Type) Dr. G. L. Gruenauer										Dr. G. L. Gruenauer	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 6, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Thompsonstown Cemetery		22d. LOCATION (City, town, or county) Near East New Market, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		ADDRESS Federalsburg, Maryland		24a. REC'D BY REGISTRAR MAR 6 '58		24b. REGISTRAR'S SIGNATURE G. L. Gruenauer					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in his office, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

BUREAU Y.

MAR 6 1953

RECEIVED

3981 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH

COUNTY Wicomico MARYLAND
 CITY (If outside corporate limits, write RURAL
 OR and give nearest town)
 TOWN Mardela Springs LENGTH OF STAY
 (In this place)
 6 weeks
 HOSPITAL OR
 INSTITUTION OR
 STREET ADDRESS Maple Shade Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Wicomico
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Mardela Springs
 STREET ADDRESS (If rural give location)

Rural

3. NAME OF
DECEASED
(Type or Print)

Bertha Caroline Shockley

4. DATE (Month) (Day) (Year)
OF DEATH Mar. 5 1958

5. SEX Female

6. COLOR OR
RACE White7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) Single10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired) At Home10b. KIND OF BUSINESS
OR INDUSTRY At Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT
COUNTRY? USA

13. FATHER'S NAME

Sylvester S. Shockley

14. MOTHER'S MAIDEN NAME

Martha W. English

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) No

(If Yes, give war or dates of service) -----

16. SOCIAL SECURITY NO.

None

17. INFORMANT & ADDRESS

Md.
Thomas Shockley, Mardela Springs

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) *influenza*
 ANTECEDENT CAUSE(S) DUE TO *Chronic Pneum*
 DISEASES OR CONDITIONS, IF ANY, (B)
 GIVING RISE TO THE ABOVE CAUSE DUE TO
 STATING UNDERLYING CAUSE LAST. DUE TO (C)

INTERVAL BETWEEN
ONSET AND DEATH

1 week

10 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

2d. AUTOPSY?
YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While Not while
at work at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from

alive on Mar. 5, 1958, and that death occurred at 10:30 P.M. from the causes and on the date stated above.

SIGNATURE

A.S. Kuhman

ADDRESS (Street, city, town, state)

3718

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

Burial

DATE THEREOF

3-8-58

NAME OF CEMETERY OR CREMATORI

Emanuel Methodist

LOCATION (City, town, or county)

3718

24. REC'D BY REGISTRAR

MAR 10 '58

REGISTRAR'S SIGNATURE

A. Schuch

25. FUNERAL DIRECTOR'S SIGNATURE

Charles W. Hammill, Shapton

DATE

PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

INSTRUCTIONS

VS AISC 1-55 10-W

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3959

CERTIFICATE OF DEATH

03952

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WICOMICO		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE VIRGINIA		b. COUNTY ACCOMAC		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN b. 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKSTUY		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ENVIRONS A GENERAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First LILLIE M.	Middle SHREVES	Last SHREVES	4. DATE OF DEATH MARCH 21 1958	Month MARCH	Day 21	Year 1958
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH April 25, 1884	9. AGE (in years last birthday) 73 yrs	10. IF UNDER 1 YEAR Months 10	11. IF UNDER 24 HRS Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Modestown		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Henry Shreves		14. MOTHER'S MAIDEN NAME Nancy Elizabeth Criley						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT J. Vincent Shreves		Address Bloxom, Va		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		ACUTE PANCREATITIS				INTERVAL BETWEEN ONSET AND DEATH Five days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		(c)				
DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Modestown		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 3-17 , 1958 to 3-21 , 1958 that I last saw the deceased alive on 3-21 , 1958, and that death occurred at 1 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Modestown, Saliney, Va.		DATE SIGNED 3-28-1958		
ACTUAL SIGNATURE J. Vincent Shreves		M.D.						
PHYSICIAN'S NAME (Type) J. Vincent Shreves		MEDICAL CENTER 5111 3631 00						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/24/58		22c. NAME OF CEMETERY OR CREMATORIAL Modestown		22d. LOCATION (City, town, or county) Modestown (State) Va.		
23. FUNERAL DIRECTOR'S SIGNATURE Robert Shreves		ADDRESS Richard Johnson Parkley, Va.		24a. REC'D BY REGISTRAR DATE MAR 27 '58		24b. REGISTRAR'S SIGNATURE Webb		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS A15 (4)
15M 9/55

BUREAU V.

JAN - 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3960

CERTIFICATE OF DEATH

Reg. Dist. No.

03953

1. PLACE OF DEATH o COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 98 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington RFD 1	
3. NAME OF DECEASED (Type or print)		First John	Middle Albert
4. DATE OF DEATH March 30, 1884		Lost Smith	Month March
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH March 30, 1884		9. AGE (In years lost birthday) 73 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during last 5 years of working life, even if retired) <i>Fisher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Fisher</i>	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Smith		14. MOTHER'S MAIDEN NAME Hannah Brinkley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. 210-12-6226	
17. INFORMANT Deer's Head Hospital Records, Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>163X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH One year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 17, 1957, to March 25, 1958, that I last saw the deceased alive on March 25, 1958, and that death occurred at 8:15 PM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>V. Juerman.</i> M.D. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 3/26/58			
PHYSICIAN'S NAME (Type) V. Juerman, M. D.		Deer's Head State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/29/58	
22c. NAME OF CEMETERY OR CREMATORIUM Mt Pleasant Cem.		22d. LOCATION (City, town, or county) Pondtown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward J. Miller Millington</i>		ADDRESS	
		24a. REC'D BY REGISTRAR PR 2	
		24b. REGISTRAR'S SIGNATURE <i>John Doe</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PUREAU V. S.

NO. 2 193

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

103954

Iter. 8, Film G227, 4/31, 1958

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Wicomico</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parsonsburg</i>		c. LENGTH OF STAY IN b. <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		e. STREET ADDRESS <i>Parsonsburg Md</i>	
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Lucy</i>	First <i>Sneed</i>	Middle <i>—</i>	Last <i>3</i>
4. DATE OF DEATH Month <i>3</i>	Day <i>20</i>	Year <i>1958</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>Che</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1903 1904</i>
9. AGE (In years to nearest birthday) <i>53</i>	10. IF UNDER 1 YEAR Months <i>—</i>	11. IF UNDER 24 HRS. Days <i>—</i>	12. IF UNDER 24 HRS. Hours <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	11. BIRTHPLACE (State or foreign country) <i>East New Market</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>E. ?</i>	14. MOTHER'S MAIDEN NAME <i>Lizzie Conffor</i>	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Edward Sneed</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <i>—hr.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Insulin - hyperglycemia</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>—</i>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Bethel Cem</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>10/18/57</i> to <i>3/20/58</i> , that I last saw the deceased alive on <i>3/20/58</i> , and that death occurred at <i>9 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Willie Sneed</i> ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <i>M.D.</i> DATE SIGNED <i>Willie Sneed M.D. Bethel Cem 10/18/57 3/20/58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-28-58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Bethel Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Bethel Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Donald Booker McWest</i>	ADDRESS <i>—</i>	24a. REC'D BY REGISTRAR <i>1 '58</i>	24b. REGISTRAR'S SIGNATURE <i>—</i>

1
7. HOSPITAL & PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 3 should be retained by the hospital or attending physician. OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PUREAU Y.

APR 2 1958

DISSEIVED

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
3961

Reg. Dist. No. 03955

FOR STATE
HEALTH DEPT.

NOTICE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by the examiner or filed. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland	
		b. COUNTY Wicomico	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. LENGTH OF STAY IN 1b 624 S. Division St		d. STREET ADDRESS 624 S. Division St	
e. IS RESIDENT ON A FARM— YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GROVER CLEVELAND STEWART		4. DATE OF DEATH Month MARCH Day 7 th Year 1958	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH April 15, 1885	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Parking Lot Attendant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John T. Stewart		14. MOTHER'S MAIDEN NAME Elizabeth Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Annie H. Stewart (Wife) 624 S. Division St. Salisbury, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO <i>Coronary occlusion</i> <i>See below</i> Conditions, if any, which gave rise to immediate cause (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Earl L. Royer</i>		DATE SIGNED March 8 1958	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL/CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 9, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM I.O.O.F. Cemetery		22d. LOCATION (City, town, or county) Laurel, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE Mar. 12 '58	
		24b. REGISTRAR'S SIGNATURE <i>R. J. Busch</i>	

RECEIVED
BUREAU V. S.

MAR 12 1959

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03956

Reg. Dist. No.

3983

1. PLACE OF DEATH a. COUNTY	Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Nanticoke Lifetime			a. STATE Maryland b. COUNTY Wicomico
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				Nanticoke
e. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH Month Day Year
Lola			Street	3- 4- 1958
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years at birthday) 76 yrs
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2/20/82	IF UNDER 16 YEARS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
Housework	Own Home	Maryland	U.S.	
13. FATHER'S NAME	Margaret Lewis			
Sidney Street	Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
No	---	Parks Young, Waterview, Maryland	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
19				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	DATE SIGNED 3-5-58			
ACTUAL SIGNATURE Earl L. Royer, M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Earl L. Royer, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22b. DATE THEREOF 3/7/58	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Oak Grove Cem.			
22d. LOCATION (City, town, or county) Jesterville, Maryland	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE C. D. Messick, Bivalve, Maryland	24a. REC'D BY REGISTRAR DATE MAR 7 '58	24b. REGISTRAR'S SIGNATURE Quinton		

BUREAU V. S.

MAR 17 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3962

CERTIFICATE OF DEATH

Reg. Dist. No.

113957

1. PLACE OF DEATH a. COUNTY <i>Nicomico</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury Maryland</i>		c. LENGTH OF STAY IN lb <i>1 day</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Robert</i>	Middle <i>S.</i>	Last <i>Taylor</i>
4. DATE OF DEATH	Month <i>March</i>	Day <i>16</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OF RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 7-1950</i>
9. AGE (In years last birthday) <i>7/89 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Student</i>	11. KIND OF BUSINESS OR INDUSTRY <i>School</i>	12. BIRTHPLACE (State or foreign country) <i>Salisbury, MD</i>
13. FATHER'S NAME <i>Robert H. Taylor</i>	14. MOTHER'S MAIDEN NAME <i>Carrie De Stefano</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Mr. Robert Taylor, Snow Hill, MD</i>	Address <i>Snow Hill, MD</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Increased Intracranial Pressure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO <i>Hydrocephalus</i>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Residence</i>	20f. (City or town) (County) (State) <i>Pemberton, NJ</i>
21. I certify that I attended the deceased from <i>Pemberton, NJ</i> to <i>Snow Hill, MD</i> , that I last saw the deceased alive on <i>19</i> , and that death occurred at <i>Snow Hill, MD</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H. H. Briele</i>	ADDRESS (Street, city or town, state) <i>721 1/2 Main Street, Pemberton, NJ</i>		
PHYSICIAN'S NAME (Type) <i>H. H. Briele</i>	DATE SIGNED <i>3/16/58</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>March 1958</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Bethel Methodist</i>	22d. LOCATION (City, town, or county) <i>Snow Hill, MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clayton & Sonne</i>	ADDRESS <i>Snow Hill, MD</i>	24a. REC'D. BY REGISTRAR DATE <i>MAR 19 1958</i>	24b. REGISTRAR'S SIGNATURE <i>H. H. Briele</i>

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3963

CERTIFICATE OF DEATH

Reg. Dist. No.

03958

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission.] a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>2 Wks.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Louise</i>	Middle <i>Fowler</i>	Last <i>Tilghman</i>		
4. DATE OF DEATH <i>March 18</i>	Month <i>March</i>	Day <i>18</i>	Year <i>1958</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 22, 1888</i>		
9. AGE (In years at birth) <i>69 yrs</i>	10. IF UNDER 1 YEAR Months <i>69</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>W. Ernest Laws</i>	14. MOTHER'S MAIDEN NAME <i>Mary Fowler</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Mr. Theodore N. Tilghman, same</i>	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Failure & Circulatory Failure</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs</i> DUE TO <i>480X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), (c) <i>Post Influenza Pneumonia</i> <i>8 days</i>					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Pine Bluff Road</i>	20f. (City or town) <i>Salisbury</i>	(County) <i>Maryland</i>	(State) <i>MD</i>
21. I certify that I attended the deceased from <i>March 10, 1958</i> to <i>March 18, 1958</i> , that I last saw the deceased alive on <i>March 18, 1958</i> , and that death occurred at <i>9:50 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Pine Bluff Road, Salisbury, Maryland</i> DATE SIGNED <i>3/18/58</i>					
ACTUAL SIGNATURE <i>Thomas C. Hill Jr.</i>	PHYSICIAN'S NAME (Type) <i>Thomas C. Hill, Jr.</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/20/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Wicomico Memorial Pk.</i>	22d. LOCATION (City, town, or county) <i>Salisbury, Maryland</i>	(State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hill & Johnson Co. Salisbury, Maryland</i>	ADDRESS <i>Norman J. Baker</i>	24a. REC'D BY REGISTRAR <i>Mar 20 '58</i>	24b. REGISTRAR'S SIGNATURE <i>John J. Baker</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician. Then please remove carbon from page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03959

3964

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 8½ mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sudlersville	
3. NAME OF DECEASED (Type or print) First George Middle Last Tiller		d. STREET ADDRESS --	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1892
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
10c. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Will Tiller		14. MOTHER'S MAIDEN NAME Janie Donald	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO 218-16-5959	
17. INFORMANT HOSPITAL RECORDS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X DUE TO Prostate gland Ca.		INTERVAL BETWEEN ONSET AND DEATH 2½ years	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pyelonephritis, chronic			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 15, 1957, to March 26, 1958, that I last saw the deceased alive on March 26, 1958, and that death occurred at 6:45 AM, from the causes and on the date stated above. ACTUAL SIGNATURE Dr. Juerman. PHYSICIAN'S NAME (Type) V. Juerman, M. D.		ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 3/26/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/31/58	
22c. NAME OF CEMETERY OR CREMATORIAL Millington Cem		22d. LOCATION (City, town, or county) Millington Md	
23. FUNERAL DIRECTOR'S SIGNATURE Elmer pillow Millington Md.		24a. REC'D BY REGISTRAR APR 2 '58	
		24b. REGISTRAR'S SIGNATURE John Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BUREAU V.

APR 2 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3965

CERTIFICATE OF DEATH

Reg. Dist. No.

03960

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 311 Penn St		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 311 Penn St		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CURTIS	Middle BENJAMIN	Last TOWNSEND	4. DATE OF DEATH MARCH 1st 1958	Month MARCH	Day 1st	Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH October 23, 1887	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee - Salisbury Times - Custodian		10b. KIND OF BUSINESS OR INDUSTRY Allen, Maryland		11. BIRTHPLACE (State or foreign country) Allen, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Benjamin Townsend			14. MOTHER'S MAIDEN NAME Mary Wesley Whayland						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT Mrs Joyce Lee Taylor (Friend)		Address 311 Penn St Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), slotting the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Disease 1 yr - INTERVAL BETWEEN ONSET AND DEATH									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Fruitland, Maryland		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec 1956 , to death , 19 1958 , that I last saw the deceased alive on March 1st 1958 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Lee L Lawry M.D. ADDRESS (Street, city or town, state) Fruitland Md. DATE SIGNED Mar. 3 1958									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 4, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Allen Cemetery		22d. LOCATION (City, town, or county) Allen, Maryland (State)			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND		ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 5 '58		24b. REGISTRAR'S SIGNATURE Levinson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

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BUREAU Y. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 11-27 3-31-55 et

3966

CERTIFICATE OF DEATH

Reg. Dist. No.

03961

1. PLACE OF DEATH a. COUNTY <i>Wisconsin</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Wisconsin</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hospital</i>		c. LENGTH OF STAY IN 1b <i>1 week</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Quonset</i>		d. STREET ADDRESS <i>RFDT 1 - Box 217</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wisconsin General Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>William</i>		First	Middle	Last	4. DATE OF DEATH <i>Mar. 17</i>	Month	Day	Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		B. DATE OF BIRTH <i>1898</i>	9. AGE (In years last birthday) <i>60 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Georgia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>?</i>				14. MOTHER'S MAIDEN NAME <i>Groves</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-16-7894</i>		17. INFORMANT <i>Elodie Mitchell</i>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under-lying cause lost. <i>Typhoid</i> DUE TO (c) <i>Generalized Arteriosclerosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>47</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>17 May 1958</i>							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>652 W Main</i>	20f. (City or town) <i>Quonset</i>	(County) <i>MD</i>	(State) <i>Wisconsin</i>	
21. I certify that I attended the deceased from <i>15 Mar. 1958</i> to <i>17 Mar. 1958</i> , that I last saw the deceased alive on <i>17 Mar. 1958</i> , and that death occurred at <i>1:30 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>E. J. Farnell</i> PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-20-58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Quonset Cem</i>		22d. LOCATION (City, town, or county) <i>Quonset MD</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Becker McLean</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>Mar 28 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. E. Edwards</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y

AR 1958

CONFIDENTIAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03962

3967 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Worcester</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pocomoke</i>		d. STREET ADDRESS <i>Route 2</i>		
NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Norris M. Trotter</i>		First	Middle	Last	4. DATE OF DEATH <i>Trotter</i>	Month	Day	Year
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 21, 1907</i>		9. AGE (In years last birthday) <i>50 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Fisher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		
13. FATHER'S NAME <i>Norris Trotter</i>		14. MOTHER'S MAIDEN NAME <i>Rosie Peachtree</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Margaret Russell</i>		Address <i>507 Bonche Blvd. Portsmouth, Va.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocarditis</i>		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. <i>Post Influenza Pneumonia</i>		DUE TO (b) <i>Post Influenza Pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 wk.</i>		
DUE TO (c)								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Pine Bluff Road, Salisbury, Md.</i>		20f. (City or town) <i>Pine Bluff Road, Salisbury, Md.</i>		(County) <i>Wicomico Co., Md.</i> (State) <i>Md.</i>
21. I certify that I attended the deceased from <i>March 15, 1958</i> to <i>March 15, 1958</i> , that I last saw the deceased alive on <i>March 15, 1958</i> , and that death occurred at <i>9:00 AM</i> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Pine Bluff Road, Salisbury, Md.</i>		DATE SIGNED <i>Thomas C. Hill Jr. M.D.</i>
ACTUAL SIGNATURE <i>Thomas C. Hill Jr. M.D.</i>								
PHYSICIAN'S NAME (Type) <i>Thomas C. Hill Jr. M.D.</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/23/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olive</i>		22d. LOCATION (City, town, or county) <i>Portsmouth, Va.</i>		(State) <i>VA</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elgar Wharton Newchurch, Va.</i>		ADDRESS <i>Newchurch, Va.</i>		24a. RECD BY REGISTRAR MAR 24 '58		24b. REGISTRAR'S SIGNATURE <i>John E. Egan</i>		

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03963

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STATE Maryland		b. COUNTY Wicomico	
Pittsville				Pittsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4 DATE OF DEATH	Month	Doy Year
Clarence		W	Truitt		3	8	19 58
5. SEX		6 COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9 AGE (In years last birthday)	10 IF UNDER 1 YEAR Months Days Hours Min	11 IF UNDER 24 HRS
M		W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	3-12-1904	53 yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12 CITIZEN OF WHAT COUNTRY?	
Nurseryman		Nursery		U S A Md.		U S A	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address			
Edward Truitt		Alice ?		217-14-8270 Mrs. Clarence Truitt, Pittsville, Md.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	
—		—		—		434.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Chronic congestive heart failure DUE TO (c)	
19. INTERVAL BETWEEN ONSET AND DEATH		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE OF INJURY	
20c. TIME OF INJURY		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	
Hour a. m. p. m.		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				(County) (State)	
19							
23. BURIAL, CREMATION OR REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)	
Burial		3/12/58		WILLARD		WILLARDS Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Anne A. Burbage Berlin Md.						DATE MAR 19 '58	
						Deceased	

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MAR 19 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3968

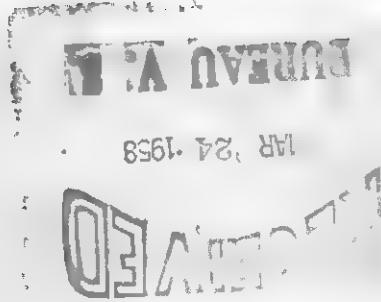
CERTIFICATE OF DEATH

Reg. Dist. No.

03964

1 PLACE OF DEATH o COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb /	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
3 NAME OF DECEASED (Type or print) First LYDIA Middle MAY Last TRUITT		d. STREET ADDRESS 306 Gay St	
4. DATE OF DEATH MARCH 20th		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 22, 1880	
9. AGE (In years at birthday) 78 yrs		10. IF UNDER 1 YEAR Months Dots Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY /	
11. BIRTHPLACE (State or foreign country) Charleston, Mo.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Frank A. Hatton		14. MOTHER'S MAIDEN NAME Lydia Jane Weller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO Miss. May H. Truitt (Daughter) 306 Gay St Salisbury, Maryland	
17. INFORMANT /		Address /	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 hrs	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes mellitus, rheumatoid arthritis		3 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June, 1951, to 3/20, 1958, that I last saw the deceased alive on 3/20/58, 19, and that death occurred at 4:45 PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Albata Mattax MD 711 Camden Ave 3/21/58	
ACTUAL SIGNATURE		DATE SIGNED	
PHYSICIAN'S NAME (Type) Dr. Alberta Mattax		Camden Ave Salisbury, Md. Mar. 21 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 22, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery		22d. LOCATION (City, town, or county) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND		ADDRESS DATE MAR 24 '58	
		24a. REC'D BY REGISTRAR	
		24b. REGISTRAR'S SIGNATURE Alberta Mattax	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3969 CERTIFICATE OF DEATH

Reg. Dist. No. 03965

1. PLACE OF DEATH a. COUNTY		Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. STATE Maryland b. COUNTY Wicomico		
Salisbury				Salisbury				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
611 Liberty St		611 Liberty St						
3. NAME OF DECEASED (Type or print)		First MARGARET	Middle IRENE	Last TURPIN	4. DATE OF DEATH	Month MARCH	Day 14 th	Year 1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Jan. 12, 1878	80	Months 2	Days 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
House Work				Bladensburg, Maryland		U S A		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				
Nathan Sumner				Florence Wailes				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		
No				Mrs. Calvin J. Parker (Daughter)		611 Liberty		
				St. Salisbury, Maryland				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO		<i>Tuberculosis</i>		INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b)		<i>Tuberculosis</i>				
		DUE TO						
		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that I attended the deceased from _____, 1950, to 3-12, 1958, that I last saw the deceased alive on 3-14, 1957, and that death occurred at 6:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____								
ACTUAL SIGNATURE		<i>Philip A. Insley</i>						
PHYSICIAN'S NAME (Type)		Main St. Parsons Cemetery, Salisbury, Maryland 31163 158						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town or county) (State)		
Burial		Mar. 16. /58		Parsons Cemetery		Salisbury, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS HOLLOWAY & COMPANY SALISBURY MARYLAND						
		24a. REC'D BY REGISTRAR DATE MAR 16 '58						
		24b. REGISTRAR'S SIGNATURE <i>C. L. Cook</i>						

BUREAU V.

MAR 13 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 11 127 3-21-58 et

CERTIFICATE OF DEATH

Reg. Dist. No. 03966

1. PLACE OF DEATH a. COUNTY Nanticoke		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Bivalve, Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 1/2 Mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield Sanitorium		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bivalve	
3. NAME OF DECEASED (Type or print) Wm. B. Messick		First Wm.	Middle B.
4. DATE OF DEATH March 12, 1958		Last Walter	Month March
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME William B. Messick		14. MOTHER'S MAIDEN NAME Margaret Larmore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	17. INFORMANT Carl L. Walter, Bivalve, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage.		INTERVAL BETWEEN ONSET AND DEATH 24 hours.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Generalized convulsions. 11 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 21 March, 1947 , to 3-12-58 , 19, that I last saw the deceased alive on 12 March, 1958 , and that death occurred at 5 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Neutroche Rd. DATE SIGNED 3/12/58	
ACTUAL SIGNATURE Robert H. Saunders, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 3/15/58		22c. NAME OF CEMETERY OR CREMATORIUM Bivalve Cem.	22d. LOCATION (City, town, or county) (State) Bivalve, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. H. Messick		24a. ADDRESS Bivalve, Maryland	24b. RECE'D BY REGISTRAR DATE MAR 21 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

MAR 21 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3971

CERTIFICATE OF DEATH

113967

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Somerset</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Saint Marys</i>		c. LENGTH OF STAY IN lb <i>82</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manokin</i>		d. STREET ADDRESS <i>19 X - 2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Renfrew General Hospital</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>SARA</i>	Middle <i></i>	Last <i>Waters</i>	4. DATE OF DEATH <i>March 18- 1958</i>	Month <i>March</i>	Day <i>18-</i>	Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 1873</i>	9. AGE (In years last birthday) yrs. <i>84</i>	IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS. Days <i></i>	Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>		11. BIRTHPLACE (State or foreign country) <i>Manokin, S. C. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Robert Robinson</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Jackson</i>		Address <i>Mrs. Edith Turner 340 Cedar Lane, Phila, Pa.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs. Edith Turner</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
						INTERVAL BETWEEN ONSET AND DEATH <i>Chloro-sclerotic Heart Disease Strength Generalized Arteriosclerosis, Insuffi-</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, p. m., from the causes and on the date stated above. ACTUAL SIGNATURE <i>E. J. Farrell</i>		ADDRESS (Street, city or town, state) <i></i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/29. 1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>John Wesley</i>		22d. LOCATION (City, town, or county) (State) <i>MANOKIN, SOMERSET MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles Howard Marion Md</i>		ADDRESS <i></i>		24a. REC'D BY REGISTRAR DATE <i>Mar 26 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. E. Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
MAR 26 1962
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03969

3972

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Nicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <i>Maryland</i>		b. COUNTY <i>Somersett</i>		
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury Md.</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Deal Island</i>		d. STREET ADDRESS <i>Main Road</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) e. INSTITUTION <i>Jenner Shula Hospital</i>				d. STREET ADDRESS <i>Main Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Robert L. Webster</i>		First	Middle	Last	4. DATE OF DEATH <i>Mar 17 1958</i>	Month	Day	Year
5. SEX <i>Male</i>		6. COLOR OR FACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 26 - 1877</i>	9. AGE (In years lost birthday) <i>78 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		11. KIND OF BUSINESS OR INDUSTRY <i>Seafood</i>		12. BIRTHPLACE (State or foreign country) <i>Maryland</i>		13. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		
13. FATHER'S NAME <i>William J. Webster</i>		14. MOTHER'S MAIDEN NAME <i>Matty MISTER</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-32-0110</i>		17. INFORMANT <i>Robert Webster - Baltimore Md.</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: < IMMEDIATE CAUSE (a) <i>Myocardial Infarct, acute</i> 430.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i>		
19. MEDICAL CERTIFICATION		20a. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20b. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Deal Island</i>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>3-17 1958</i> to <i>3-17 1958</i> , that I last saw the deceased alive on <i>3-17 1958</i> , and that death occurred at <i>9:30 PM</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Salisbury, Md.</i>		DATE SIGNED <i>3-17-58</i>		
ACTUAL SIGNATURE <i>William J. Webster</i>								
PHYSICIAN'S NAME (Type) <i>Ellis J. M.D.</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Mar 20 1958</i>		22c. NAME OF CEMETERY OR Crematory <i>St. John's Methodist</i>		22d. LOCATION (City, town, or county) <i>Deal Island</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. D. Webster</i>		ADDRESS <i>Deal Island Md.</i>		24a. REC'D BY REGISTRAR <i>Asst. Reg.</i>		24b. REGISTRAR'S SIGNATURE <i>Asst. Reg.</i>		
				DATE MAR 21 '58				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE BANK - MILWAUKEE - WISCONSIN

REGISTRATION OF DEATH

BUREAU V. S.

MAR 21 1968

RECEIVED